CLINICAL TRAINING SKILLS *for* REPRODUCTIVE HEALTH PROFESSIONALS

SECOND EDITION

Authors

Rick Sullivan
Ann Blouse
Noel McIntosh
Lois Schaefer
Elaine Lowry
Gary Bergthold
Ron Magarick

JHPIEGO CORPORATION

1615 Thames Street
Baltimore, Maryland 21231-3492

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JHPIEGO, an affiliate of Johns Hopkins University, is a nonprofit corporation dedicated to improving the health of women and families throughout the world. JHPIEGO works to increase the number of qualified health professionals trained in modern reproductive healthcare, especially family planning.

JHPIEGO Corporation
Brown's Wharf
1615 Thames Street, Suite 200
Baltimore, Maryland 21231-3492, USA
http://www.jhpiego.jhu.edu

Authors: Rick Sullivan
Ann Blouse
Noel McIntosh
Lois Schaefer
Elaine Lowry
Gary Bergthold
Ron Magarick

Editor: Dana Lewison

Production Assistance: Deborah Brigade

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Authors: Rick Sullivan
Ron Magarick
Gary Bergthold
Ann Blouse
Noel McIntosh

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PREFACE

This manual was first published in 1995. It continues to be the cornerstone of JHPIEGO's trainer development pathway (see **Chapter 1**), and its use has led to the development of two additional manuals—*Instructional Design Skills for Reproductive Health Professionals* (1997) and *Advanced Training Skills for Reproductive Health Professionals* (forthcoming 1999). Together, these manuals can help an expert service provider become first an effective clinical trainer who trains other service providers, and later an advanced and possibly master trainer who trains other trainers and designs training courses.

The need for a second edition became apparent as the *Advanced Training Skills* manual was field-tested. Clinical trainers commented that several chapters in that manual contained information that would have been more useful to them earlier, when they acquired and first applied their training skills. Our experience in conducting clinical training skills courses also suggested that some of the manual content should be edited, reorganized or augmented. With this in mind, the authors revised the manual to include new chapters on planning for a training course and managing clinical practice. The chapter on creating a positive learning climate was expanded to include a section on understanding group dynamics. All learning activities, from illustrated lectures to small group activities, are now described in one chapter. The chapters on coaching and clinical training techniques have been combined in order to more fully integrate the concept of coaching with the clinical trainer's role as a coach in the development of skills. Also, at the suggestion of trainers who used the first edition of the manual, we have added to many of the chapters "Situations" which describe problems that trainers frequently encounter when they give training courses. Readers are asked to write down how they would resolve these problematic situations, and then compare their solutions to the "Responses" given at the end of the chapter.

The authors gratefully acknowledge the valuable assistance of our international colleagues, representatives from other organizations and JHPIEGO staff who have used this manual. We are indebted to them for their suggestions and comments.

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INTRODUCTION

Since the 1970s, use of modern contraceptives has increased dramatically throughout the world, helping to improve the reproductive health of many women. According to recent estimates, however, over 350 million couples worldwide still lack access to the full range of family planning methods (UNFPA 1997). Family planning, however, is just one of the many services that must be offered in order to improve reproductive health. According to the World Health Organization (1998) and UNFPA (1997):

- Every year, 585,000 women die (more than one every minute) from pregnancy-related causes—the overwhelming majority of them in developing countries.

- In 1995, girls aged 15 to 19 gave birth to 17 million babies.

- Over 330 million new cases of sexually transmitted diseases occur every year.

These and other statistics point to the increasing demand for accessible, high quality reproductive health services, and the corresponding need for qualified reproductive health professionals to provide these services.

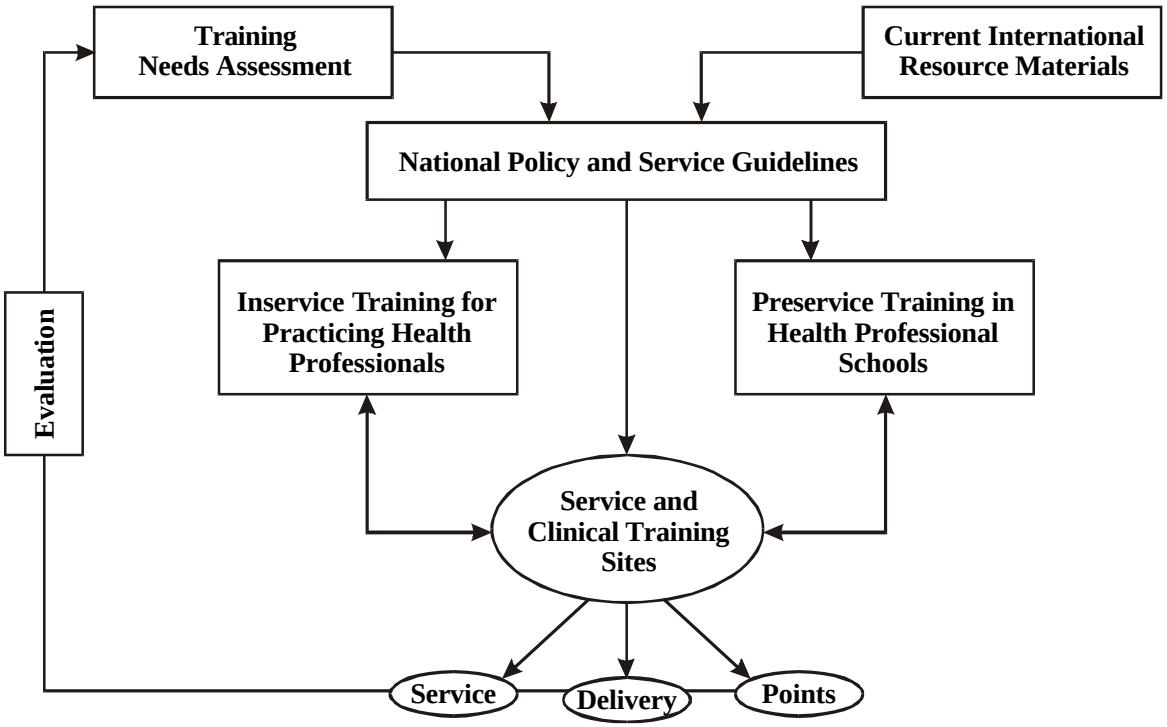
This reference manual, *Clinical Training Skills for Reproductive Health Professionals*, second edition, describes a mastery learning approach to clinical skills training. It was designed to help **expert service providers** become **effective clinical trainers** who can, in turn, train other service providers in clinical reproductive health skills such as IUD insertion or infection prevention. Training based on this approach is creating cadres of skilled clinical trainers in many countries around the world.

FRAMEWORK FOR INTEGRATED REPRODUCTIVE HEALTH TRAINING

Reproductive health training in a country may be seen as a network of pathways aimed at linking the national system of higher education, the healthcare system, the political system and cultural norms to strengthen reproductive health policy, training and services. This integrated training model (**Figure 1**) brings together the educational and health systems of a country to focus on the preparation of a cadre of providers who can deliver standardized, high quality services. Preservice and inservice training are harmonized and coordinated in the framework. The clinical trainer who is based at the service and clinical training sites may have responsibilities in both of these areas. Therefore, it is important that the

trainer understand all components of this framework for reproductive health training.

Figure 1-1. Framework for Integrated Reproductive Health Training



The framework has the following components:

- **Needs assessments** are conducted at national, institutional and facility levels to document how constraints to high quality family planning service delivery can be addressed through preservice education or inservice training.

- **International resource materials** and accurate scientific information on reproductive health are essential to the development of national policy and guidelines if a country wishes to maximize the quality of its services and eliminate unnecessary barriers to their provision. Inservice training and preservice education disseminate and promote use of these guidelines.

- **National policy** defines a government's strategy toward reproductive health (e.g., who will receive services, which services will be provided, through which service delivery mechanisms they will be provided, what the standards of quality will be). **Service guidelines**

are more technically focused and specifically address the provision of services (e.g., how each service is to be provided, who should deliver specific services, what counseling should accompany each service, what the indications and precautions are for each contraceptive method, how side effects and complications should be managed, what the minimum requirements are for delivery of each service).

- **Inservice training** helps ensure that health professionals already providing services have the opportunity to update their knowledge and skills according to the latest scientific information and practices.

- **Preservice education** or training represents all the institutions (e.g., schools of medicine, nursing, midwifery) that are concerned with initial or basic education and training of health service providers at all levels.

- **Service and clinical training sites** for both the preservice and inservice systems are treated the same way: all are standardized to the national service delivery guidelines with regard to essential equipment, supplies, infection prevention practices and reproductive health services.

- **Service delivery points** are those sites where trained clinical service providers work to provide high quality reproductive health services.

- **Evaluation** approaches are used to provide feedback to assess how well the integrated training system is functioning and what impact it has made on service delivery.

Based on the results of needs assessments, preservice and inservice training interventions (e.g., courses, workshops, updates, seminars) consistent with national policy and service delivery guidelines may be required to furnish service providers with the knowledge and skills they need to provide high quality services. Proficient clinical trainers help ensure that these training interventions are implemented in a logical and systematic manner to support the integrated reproductive health training framework.

TERMS USED IN THIS MANUAL

Learning is the acquisition of new knowledge, attitudes and skills. It may occur formally during a learning event or informally during personal reading and study. Learning is a lifelong process.

A **learning event** is an activity conducted for the purpose of transferring knowledge, attitudes and/or skills to participants. It can take the form of a course, workshop, seminar, contraceptive technology update or other type of event. Throughout this manual, **course** will be used to describe an event in which clinical training occurs.

Learning that takes place in medical, nursing and midwifery schools is known as **preservice education**. In preservice education, **students** attend classes taught by preservice **faculty** who are responsible for teaching in the classroom (also referred to as classroom faculty or instructors). Individuals with clinical responsibilities in preservice education are known as **clinical preceptors** or **clinical instructors**.

Inservice training provides new information and skills to health professionals who have completed their preservice education. They may also need periodic training to "refresh" the knowledge and skills acquired earlier. Individuals responsible for conducting these courses are known as **trainers**, and those attending inservice courses are referred to as **participants** or **learners**.

The learning approaches presented in this manual can be applied to preservice education as well as inservice training. To simplify the manual, **clinical trainer** or **trainer** will be used to refer to the individual responsible for conducting the course. **Participant(s)** will be used to describe individuals attending the course.

ONE

AN APPROACH TO CLINICAL TRAINING

INTRODUCTION

The training approach described in this chapter is guided by principles of adult learning. These principles are based on the assumption that people participate in training courses because they:

- Are **interested** in the topic
- Wish to **improve** their knowledge or skills, and thus their job performance
- Desire to be **actively involved** in course activities

WHAT I HEAR, I FORGET;

WHAT I SEE, I REMEMBER;

WHAT I DO, I UNDERSTAND.

To be effective, clinical trainers must use appropriate training strategies. The participatory, "hands-on" training techniques emphasized in this manual are best reflected in this ancient proverb.

Chapter Objective

After completing this chapter, the participant will be able to describe a mastery learning approach that incorporates adult learning principles and features competency-based training, coaching and humanistic training techniques.

Enabling Objectives

To attain the chapter objective, the participant will:

- Identify the goal of clinical training
- Describe the mastery learning approach to training
- Describe the key features of effective clinical training
- Identify the responsibilities of clinical trainers and participants
- Identify the criteria for selecting and training clinical trainers

GOAL OF CLINICAL TRAINING

The goal of clinical training is to assist health professionals in learning to provide safe, high quality reproductive health services to clients through improved work performance. **Training** deals primarily with obtaining the

knowledge, attitudes and skills needed to carry out a specific procedure or activity, such as inserting an IUD or providing counseling. Training presumes an immediate application of the information or physical skill(s) being learned.

Education, in contrast, is defined most often in terms of future goals. For example, an individual attends a school or university in order to prepare for a future role as a nurse or doctor. The student's education provides a broad array of knowledge (and skills) needed to perform that role and from which s/he can later select what is needed, according to a given situation.

No matter how effective training is in conveying information or influencing attitudes, if participants are unable to satisfactorily perform the procedure or activity assigned to them, the training will have failed. Therefore, clinical trainers must focus their energies on modeling the appropriate attitudes as well as transferring skills and providing the facts that participants need to do their jobs.

Effective clinical training emphasizes application of knowledge and attitudes in the performance of skills.

MASTERY LEARNING

The **mastery learning** approach to clinical training assumes that all participants can master (learn) the required knowledge, attitudes and skills provided sufficient time is allowed and appropriate training methods are used. The goal of mastery learning is that 100 percent of those being trained will "master" the knowledge and skills on which the training is based. While some participants are able to acquire new knowledge or a new skill immediately, others may require additional time or alternative learning methods before they are able to demonstrate mastery. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken or visual means. Mastery learning takes these differences into account and uses a variety of teaching and training methods.

The mastery learning approach also enables the participants to have a self-directed learning experience. This is achieved by having the clinical trainer serve as facilitator and by changing the concept of testing and how test

results are used. In courses that use traditional testing methods, the trainer administers pre- and post-tests to document an increase in the participants' knowledge, often without regard to how this change affects job performance.

By contrast, the philosophy underlying the mastery learning approach is one of continual assessment of participant learning. With this approach, it is essential that the clinical trainer regularly inform participants of their progress in learning new information and skills and **not** allow this to remain the trainer's secret.

With the mastery learning approach, a precourse knowledge assessment (e.g., precourse questionnaire) is used to determine what the participants, individually and as a group, know about the course content. This allows the clinical trainer to identify topics that may need additional emphasis or, in many cases, those that will require less classroom time during the course. Providing the results of the precourse assessment to participants enables them to focus on their individual learning needs. A second knowledge assessment, the midcourse questionnaire, is used to assess the participants' progress in learning new information. Again, results of this assessment are reviewed with participants.

With the mastery learning approach, assessment of learning is:

- **Competency-based**, which means assessment is keyed to the course objectives and emphasizes acquiring the essential knowledge, attitudinal concepts and skills needed to perform a job, not simply acquiring new knowledge.

- **Dynamic**, because it enables clinical trainers to provide participants with continual feedback on how successful they are in meeting the course objectives and, when appropriate, to adapt the course to meet learning needs. (Trainers using pre- and post-tests often do **not** review the correct answers with the participants. As a consequence, participants may leave the course not knowing why some of their answers were incorrect.)

- **Less stressful**, because from the outset participants, both individually and as a group, know what they are expected to learn and where to find the information, and have ample opportunity for discussion with the clinical trainer.

KEY FEATURES OF EFFECTIVE CLINICAL TRAINING

Effective clinical training is designed and conducted according to **adult learning principles**—learning is participatory, relevant and practical—and:

- Uses **behavior modeling**
- Is **competency-based**
- Incorporates **humanistic training techniques**

Each of these features is described briefly in this section.

Adult Learning Principles

The training techniques and approaches discussed throughout this manual are based on the following eight principles:

- Learning is most productive when participants are **ready to learn**. Although motivation is internal, it is up to the clinical trainer to create a climate that will nurture motivation in participants.
- Learning is more effective when it **builds** on what the participants already know or have experienced.
- Learning is more effective when participants are **aware** of what they need to learn.
- Learning is made easier by using a **variety** of training methods and techniques.
- Opportunities for **practicing** skills initially in controlled or simulated situations (e.g., through role play or use of anatomic models) are essential for **skill acquisition** and for development of **skill competency**.
- **Repetition** is necessary for participants to become competent or proficient in a skill.
- The more **realistic** the learning situation, the more effective the learning.
- To be effective, **feedback** should be **immediate**, **positive** and **nonjudgmental**.

Behavior Modeling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone else perform (model) a skill or activity. For modeling to be successful, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them.

Learning to perform a skill takes place in three stages (**Figure 1-1**). In the first stage, **skill acquisition**, the participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure, usually with supervision. Next, the participant practices until **skill competency** is achieved and s/he feels **confident** performing the procedure. The final stage, **skill proficiency**, only occurs with repeated practice over time.

Figure 1-1. Levels of Performance

Skill Acquisition	Knows the steps and their sequence (if necessary) to perform the required skill or activity but **needs assistance**
Skill Competency	Knows the steps and their sequence (if necessary) and **can perform** the required skill or activity
Skill Proficiency	Knows the steps and their sequence (if necessary) and **efficiently performs** the required skill or activity

Competency-Based Training

Competency-based training (CBT) is distinctly different from traditional educational processes. Competency-based training is learning by **doing**. It focuses on the specific knowledge, attitudes and skills needed to carry out a procedure or activity. How the participant performs (i.e., a combination of knowledge, attitudes and, most important, skills) is emphasized rather than just what information the participant has acquired. Moreover, CBT requires that the clinical trainer facilitate and encourage learning rather than serve in the more traditional role of instructor or lecturer. Competency in the new skill or activity is assessed objectively by evaluating overall performance. While CBT traditionally has been used for inservice training, elements of this approach are applicable to the preservice setting as well. Finally, CBT has a sound scientific basis. As shown in **Table 1-1**, a person's ability to recall essential information is vastly increased when the material is learned through participatory methods, rather than through more passive methods such as listening to a lecture or obtaining new information through reading.

Table 1-1. Learning Recall Related to Type of Presentation

TYPE OF PRESENTATION	PERCENTAGE OF MATERIAL RECALLED	
	After 3 Hours	After 3 Days
Verbal (one-way) lecture	25%	10–20%
Written (reading)	72%	10%
Visual and verbal (illustrated lecture)	80%	65%
Participatory (role plays, case studies, practice)	90%	70%

Adapted from: Dale 1969.

For CBT to occur, the clinical skill or activity to be taught must first be broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. This process is called **standardization**. Once a procedure, such as insertion of Norplant® implants, has been standardized, competency-based skill development (learning guides) and assessment (checklists) instruments can be designed. These instruments make learning the necessary steps or tasks easier and evaluating the participant's performance more objective (see **Chapter 6**).

An essential component of CBT is **coaching** (see **Chapter 7**), which uses positive feedback, active listening, questioning and problem-solving skills to encourage a positive learning climate. Unfortunately, the teaching model with which most health professionals are familiar is the classroom instructor lecturing to a group of students who anxiously take notes so that they can pass a written examination. This approach to teaching, used by a skilled clinical trainer, can be effective in providing basic knowledge. It is, however, a very poor way of transferring clinical skills (such as inserting an IUD), strengthening problem-solving skills or changing attitudes towards clinical practice.

What is needed is an approach to clinical training that is different from classroom teaching. Coaching has been used successfully for technical training in industry for many years. To use coaching, the clinical trainer should first explain the skill or activity and then demonstrate it using an anatomic model or other training aid such as a slide set or videotape. Once the procedure has been demonstrated and discussed, the trainer/coach then observes and interacts with the participant to provide guidance in

learning the skill or activity, monitors progress and helps the participant overcome problems.

The coaching process ensures that the participant receives feedback regarding performance:

- **Before practice**—The clinical trainer and participant should meet briefly before each practice session to review the skill/activity including the steps/tasks that will be emphasized during the session.

- **During practice**—The clinical trainer observes, coaches and provides feedback to the participant as s/he performs the steps/tasks as outlined in the learning guide.

- **After practice**—This feedback session should take place immediately after practice. Using the learning guide, the clinical trainer discusses the strengths of the participant's performance and also offers specific suggestions for improvement.

When CBT is integrated with **adult learning principles** and is based on **behavior modeling**, the result is a powerful and extremely effective method for providing technical training. And, when the use of **anatomic models and other learning aids** is incorporated, training time (and training costs) can be reduced significantly.

Humanistic Training Techniques

The use of more humane (humanistic) techniques also contributes to better clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids such as slide sets and videotapes. The effective use of models facilitates learning, shortens training time and minimizes risks to clients. For example, by using anatomic models initially, participants more easily reach the performance levels of skill competency and beginning skill proficiency before they begin working in the clinic setting with clients (see **Figure 1-1**).

Before a participant attempts a clinical procedure with a client, two learning activities should occur:

- The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g., slide sets or videotapes).

- While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting which is as similar as possible to the real situation.

The number of procedures participants need to observe, assist with and perform using models will vary depending on their backgrounds. Only when skill competency and some degree of skill proficiency have been demonstrated with models, however, should participants have their first contacts with clients.

Incorporating the use of anatomic models and other learning aids can significantly reduce training time and the number of cases needed for skill competency. Practicing with models also helps participants correct mistakes in technique that could hurt the client. For example, in a study conducted in Thailand in 1991, the traditional IUD training method (6-week course) was compared with a 2-week course using the CBT approach described above. When participants were allowed to learn and practice repeatedly with pelvic models, 70 percent of the 150 participants were judged to be competent after just two insertions with clients, and 100 percent by six. By contrast, of the 150 participants taught without the use of pelvic models, 50 percent obtained competency only after an average of 6.5 insertions, and 10 percent never achieved competency (i.e., were not qualified) even after 15 (Limpaphayom et al 1997; McIntosh 1993).

RESPONSIBILITIES OF THE CLINICAL TRAINER AND COURSE PARTICIPANTS

In CBT, the responsibility for meeting learning objectives is shared by the clinical trainer and each participant. The clinical trainer's goal is to help each participant attain full competency in a skill or activity, not just earn a high grade on a test of knowledge. If a participant does not reach full competency, the clinical trainer should not attribute failure simply to the participant's lack of ability, but should look for ways to improve training methods or provide additional practice for the participant.

The role of the clinical trainer is to facilitate learning. The clinical trainer guides participants toward the discovery of new knowledge and the acquisition of new or improved skills. The clinical trainer also seeks to influence participant attitudes by serving as a role model. For example, the trainer always should demonstrate the skill completely and accurately—poor performance is never acceptable.

Participants are actively involved in the learning process, and are encouraged to contribute what they know about the topic being discussed. The knowledge that participants bring to the training situation is as essential to the total training process as the knowledge that the clinical trainer offers. The success of this approach is based on the willingness of participants to take an active part in the training and to share their

experiences and knowledge with other group members.

SELECTING AND TRAINING CLINICAL TRAINERS

The key to successful clinical training is transference: assisting health professionals who are experts in their field in learning how to transfer their knowledge and skills to others.

In international business and industry, organizations are finding that it is better to select outstanding technical (content) experts and teach them training skills, rather than to use training professionals who are not proficient in the technical skills being taught.

Perhaps the most crucial decision in designing a clinical training course is the selection of the trainer(s). It often has been assumed that anyone with strong academic credentials and good clinical skills can be a trainer, but experience in many parts of the world has shown that performing and teaching clinical skills are two very different things.

In selecting potential clinical trainers, the following criteria should be considered:

- **Demonstrated proficiency.** The individual must first be an expert service provider in the clinical skill(s) to be taught.

- **Interest in training.** A health professional who is genuinely interested in training will be more likely to take the time necessary to learn and practice clinical training skills.

- **Humility.** A good clinical trainer is able to admit when she or he makes mistakes, and does not try to prove that participants will never attain her/his skill level.

Process for Becoming a Clinical, Advanced and Master Trainer

Until recently, trainers had few ways to learn training skills. To some it came "naturally," but usually only after many years of trial and error. A fortunate few had the opportunity of being taught by good clinical trainers whose style they could copy. For most, however, little training in these skills was available. It is recommended that a series of steps be used to assist clinicians in making the transition from service provider to clinical trainer to advanced and finally to master trainer (see **Figure 1-2**).

First, the clinician must acquire service delivery skills, such as counseling or IUD insertion, through training and experience. Over a period of time, usually months or even years of repeated practice, the clinician becomes expert (proficient) in providing the clinical skill or activity.

After becoming a proficient service provider, the clinician who wants to become a clinical trainer may attend a clinical training skills course which focuses on learning the skills necessary to transfer her/his expertise to others effectively. During this course, s/he will learn coaching and humanistic training techniques which are based on adult learning principles. In addition, the clinician will learn a standardized approach to performing the clinical procedure and how to use competency-based skill assessments to evaluate participant performance. S/he will also learn how to present information more effectively through use of illustrated lectures, demonstrations, role plays, case studies, group discussions and audiovisuals and other learning aids.

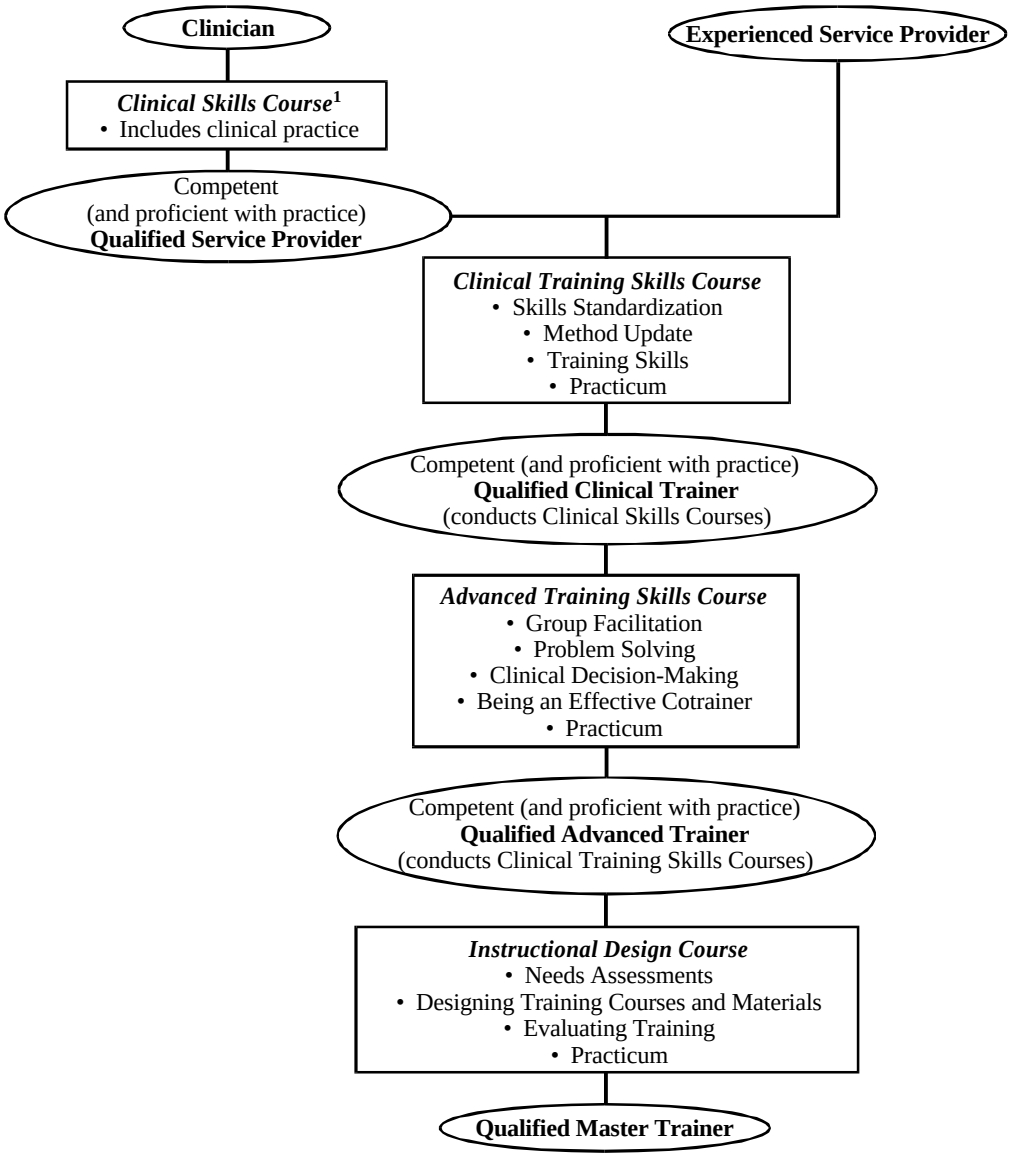
Following this, the new clinical trainer should serve as a cotrainer for one or more clinical training courses for service providers. If possible, cotraining should be done with the advanced trainer who taught the clinical training skills course. In subsequent courses, as the new clinical trainer becomes more skilled in training, s/he will be assisted by an advanced trainer only as needed.

Once proficient, the clinical trainer selected to become an advanced trainer will focus on learning the skills necessary to effectively transfer her/his training expertise to others by training them as clinical trainers. During this course, the individual will learn to use group facilitation, problem-solving and clinical decision-making skills, and to serve effectively as a cotrainer.

The advanced trainer will then conduct several clinical training skills courses, usually with an advanced or master trainer. Over a period of time the advanced trainer strengthens and expands her/his skills through training delivery.

Selected advanced trainers may have the interest and capabilities to pursue additional training in the area of instructional design. While this training focuses on designing appropriate training courses and materials, information is included on needs assessments and evaluation of training. Instructional design training is also appropriate for preservice faculty members who may not have responsibility for clinical skills training. An individual who undergoes training and gains appropriate experiences in clinical, advanced and instructional design training skills and needs assessments/evaluation may be considered a master trainer.

Figure 1-2. Trainer Development Process



[1] Clinical Skills Courses = IUD, infection prevention, Norplant® implants, minilaparotomy, etc.

SUMMARY

Clinical training in family planning assists healthcare workers in performing their jobs more effectively. When mastery learning that is based on adult learning principles and behavior modeling is integrated with CBT, the result is a powerful and extremely effective method for

providing clinical training. And when humanistic training techniques such as using anatomic models and other learning aids are incorporated, training time and training costs can be reduced significantly.

Because the goal of clinical training is to help healthcare workers learn to provide safe, high quality services, the responsibility for achieving the training objectives is shared by the clinical trainer and each participant. If a participant does not meet the course objectives, the clinical trainer should not simply attribute failure to the participant's lack of ability, but should look for additional ways to assist the participant and improve training methods.

Finally, not every expert service provider can become a good clinical trainer. Therefore, the criteria for selecting potential candidates should include a sincere interest in training, in addition to proficiency in a clinical skill or activity.

TWO

PLANNING FOR A TRAINING COURSE

INTRODUCTION

A successful training course does not come about by accident, but rather through careful planning. This planning takes thought, time, preparation and often some study on the part of the clinical trainer. In most cases, designing the clinical course will be the responsibility of a master trainer, while conducting the course will be the role of a clinical trainer. To design an effective course, a trainer needs special knowledge and experience in order to write primary and enabling objectives and select appropriate training methods and materials. These topics are beyond the scope of this manual.[1]

Each trainer may have a different level of involvement in planning and organizing a course. The level of involvement will depend on whether the trainer is a staff member of the sponsoring organization, a staff member of the institution where the training will be conducted or a national or regional consultant. In any case, the clinical trainer needs to be thoroughly familiar with the issues surrounding course planning. In most circumstances, clinical trainers are not expected to develop the course, but are asked to adapt an existing course to the local setting and conduct it using suitable training methods.

The trainer is responsible for ensuring that the course is carried out essentially as it was designed. The trainer must make sure that the clinical practice sessions, which are an integral part of a clinical skills course (see **Chapter 8**), as well as the classroom sessions, are conducted appropriately. In addition to taking responsibility for the organization of the course in general, the trainer must also be able to give presentations and demonstrations and lead other course activities, all of which require prior planning. Well-planned and executed classroom and clinic sessions will help to create a positive learning experience (see **Chapter 3**).

Chapter Objective

After completing this chapter, the participant will be able to plan a clinical training course.

[1] For information on course design, see Sullivan R and L Gaffikin. 1997. *Instructional Design Skills for Reproductive Health Professionals.* JHPIEGO Corporation: Baltimore, Maryland.

Enabling Objectives To attain the chapter objective, the participant will:

- Consider general planning issues
- Ensure appropriate participant selection
- Review the required course materials
- Select and make arrangements for the classroom
- Select and make arrangements for the clinic

GENERAL PLANNING ISSUES

Planning a clinical training course requires a considerable amount of time and attention to detail and ideally should begin at least 6 months before the course. A typical timeline for planning activities is presented in **Table 2-1**. The trainer can obtain information about the classroom and clinical requirements for the course, as well as the materials, supplies and equipment needed for each learning activity, from the course outline in the trainer's notebook (see section on Course Materials). The clinical trainer is responsible for making sure that these items are available and organized before the course begins. A detailed checklist of tasks for the trainer can be found in **Sample 2-1**.

In order to plan effectively for classroom and clinical facilities, course materials and other requirements, the trainer must know well in advance how many participants will be attending the course. After determining the number of participants, the trainer should check on the following course requirements:

- Adequate space for classroom and clinical activities
- Learning materials, including whether they will require adaptation
- Any supplemental written materials for the learning activities (e.g., role play, case study)
- Supplies and equipment (e.g., flipcharts, paper and pencils, anatomic models, surgical instruments, bleach, buckets); **Sample 2-2** lists the items needed to conduct a 2-week IUD clinical skills training course.

Table 2-1. Suggested Timeline for Preparing for a Clinical Skills Training Course

TIME PRIOR TO COURSE	ACTIVITY
6 months	Confirm training site (classroom and clinical facilities) Select housing accommodations (if necessary) Select and confirm clinical training consultants or special content experts (if necessary) Meet with staff at clinical training site
3 months	Select and notify participants Initiate administrative arrangements Confirm housing accommodations Reconfirm clinical training consultants or content experts Order learning materials, supplies and equipment Confirm arrangements to receive participants at the clinical training facility
1 month	Review course syllabus, schedule and outline and adapt if necessary (if possible, send copies of the syllabus and schedule to participants and other clinical trainers) Review content material and prepare for each session to be delivered by clinical trainer Prepare audiovisuals (transparencies, slides, flipcharts, etc.) Arrange for all audiovisual equipment (overhead projector, video player, monitor, slide projector, etc.) Visit classroom training site and confirm arrangements Visit clinical training site(s) and confirm arrangements Confirm receipt of learning materials, supplies and equipment Finalize administrative arrangements Reconfirm housing arrangements
1 week	Review final list of participants for information on experience and clinical responsibilities Review the course syllabus and outline Assemble learning materials Prepare statements of qualification or participation Reconfirm availability of clients at clinical training site Meet with cotrainer(s), clinical training consultants or special content experts to review individual roles and responsibilities
1 to 2 days	Prepare classroom facility Prepare and check audiovisual equipment and other learning aids Arrange anatomic models and all needed instruments and supplies Check with cotrainers to be sure there are no other arrangements that need to be made

One of the most important considerations in selecting a training site is finding a good classroom facility that is near an appropriate clinical facility. The organizers of the course must weigh the advantages and disadvantages of selecting a training site close to where the majority of the participants work. Conducting a course in, or even near, the workplace can cause numerous interruptions and distractions. Conversely, the greater the distance the classroom and clinical sites are from the participants' work sites, the greater the costs of transportation and housing.

There are a number of administrative arrangements for which the clinical trainer will have no direct responsibility, such as arranging for housing accommodations or per diem payments. In the interest of minimizing problems at the beginning of the course, however, the clinical trainer should work closely with the person who is handling these arrangements to make certain that all administrative details are taken care of promptly. These details include:

- Scheduling classroom and clinic site(s) and informing appropriate staff of upcoming training
- Confirming financial support, including how travel costs, per diem payments or housing allowances will be paid to or on behalf of the participants
- Making arrangements for participants, including housing accommodations and transportation to and from the course
- Providing pertinent information to participants (e.g., course syllabus, financial and housing arrangements)
- Obtaining learning materials, equipment and supplies needed for course activities, including clinic practice (if necessary)

SELECTING PARTICIPANTS

Situation 1: During the introductions at the beginning of a clinical skills course for service providers, you discover that one of your participants does not meet the selection criteria and should not be participating in the course. What would you do?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Selection of appropriate participants is critical to the success of any course. The trainer may have an excellent course design, materials, clinical and classroom facilities and supporting audiovisuals, but these mean very little if the wrong participants attend the course. Having clear, agreed-upon criteria for course participants is crucial.

For most courses there is a **syllabus** (see **Sample 2-3**) which contains information about a course. A key element of the course syllabus is the **participant selection criteria**. Once the individuals planning the course have a clear understanding of these criteria, they can help to make certain that the types of individuals selected to attend are those for whom the event was designed.

Selecting Participants for a Clinical Skills Course

The following criteria should be considered when selecting participants for a **clinical skills course** (e.g., IUD, Norplant implants):

- Participants must be reproductive health professionals (e.g., physician, nurse, nurse midwife) who are **currently providing services**.

- Participants should have an **interest** in providing the family planning service(s) upon which the course is based.

- The participants' institution (e.g., clinic, hospital) should be **capable of offering the family planning service(s)** upon which the course is based (i.e., has adequate number of clients, staffing, clinic space, supplies, infection prevention practices, counseling capability).

- Participants should have the **support of their supervisors or managers**. To achieve improved job performance, the trainer should communicate with supervisors and managers whenever possible and ask that they endorse the clinical training, encourage attendance and participation, take part in planning the transfer of new knowledge and skills to the job and provide support when the clinician who has received training begins to apply newly acquired skills on the job.

- Two individuals from each site should attend training, when appropriate. **Training pairs of clinicians** makes it more likely that the new skills will be used when participants return to their sites, because they will be able to assist and coach each other at their workplace.

Participants should be selected and notified **2 to 3 months** in advance of the course, whenever possible. As part of their invitation, participants (and their supervisors, if appropriate) should be sent information about the course. In addition to the dates, location and logistical information,

participants should receive a copy of the course syllabus from the participant's handbook. The syllabus describes the course and its goals, learning materials, participant selection criteria and how the participants will be evaluated.

If all the participants are coming from the same geographic area and the trainer has the organizational and financial support to do so, **visiting the clinical sites** of some or all of the participants before a course has several advantages. The trainer can observe clinical skills, assess infection prevention practices, discuss client caseload, observe counseling procedures and provide information to staff concerning the upcoming course. The trainer is then in a better position to determine that course objectives, content and activities match the needs and capabilities of the participants. Furthermore, those attending training will have established a relationship with the trainer and have a clearer understanding of what they will learn in the course.

COURSE MATERIALS

Use of standardized learning materials helps ensure consistency in the transfer of knowledge and skills and in objective evaluation of participant performance. Clinical trainers are therefore often provided with pretested **learning packages** which contain all the materials the trainer will need to conduct the course. A typical learning package usually consists of:

- A content-specific reference manual
- Courseware for the participant and trainer (e.g., a participant's handbook and trainer's notebook)
- Anatomic models and audiovisual or other learning aids

The **reference manual** provides all of the essential information needed to conduct the course in a logical manner. Because it serves as the "text" for the participants and the "reference source" for the clinical trainer, special handouts usually are not needed. Country-specific supplemental material, however, may be prepared and distributed as appropriate. Such material could include information on the country's demographic profile, medical records and reporting system, local drug lists and the like. Because the

manual contains only information that is consistent with course goals and objectives, it becomes an integral part of all classroom exercises—from giving an illustrated lecture to providing problem-solving information. Finally, it provides a readily available reference for problem solving and review of newly learned information when participants return to their home clinics or hospitals.

The **participant's course handbook** serves as the road map to guide the participant through each phase of the course. It contains a model course syllabus and schedule as well as all supplemental printed materials such as the precourse knowledge assessment, skill development learning guides and course evaluation.

The **trainer's notebook** contains the participant's handbook materials as well as trainer-specific information such as the course outline, answer keys to the pre- and midcourse questionnaires, and competency-based knowledge and skill assessment instruments.

Anatomic models, audiovisual and other learning aids are used for classroom demonstrations and practice of skills and activities. Examples include a pelvic model (ZOE®) for IUD skills training or the training arm for Norplant implants training, as well as videotapes.

If the course materials are not organized as a "learning package," the clinical trainer should develop a course syllabus, outline and schedule. These are described in **Chapter 9**.

Adapting Course Schedules and Other Materials

Situation 2: You have been conducting very successful 10-day IUD courses. You are asked to conduct the same course for the same number of participants, but to do it in only 5 days. How would you respond to this request?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

When trainers are learning to use a standardized learning package (e.g., training for IUD insertion and removal), they focus on how to use the components of the package to conduct the course as designed. But as trainers become proficient at delivering the standardized course, they will begin to see ways in which it may be adapted to meet special course requirements or participant needs.

The course outline and schedule are intended to serve as a model for the clinical trainer, and are designed to permit the course participants and clinical trainer the widest possible latitude in adapting the training to the

participants' individual and group learning needs. Before the course, the clinical trainer should determine what changes, if any, are needed regarding allocation of classroom and clinic time. For example, client availability is a critical factor in assuring that the participants will have enough supervised time in the clinic setting to become competent and confident in their skills. The schedule may have to be modified to accommodate the clinic schedule or the number of course participants.

There are a number of reasons the trainer would adapt the learning package for a clinical skills course, including:

- The number of days available to conduct the course differs from the number of days in the model course schedule.
- The number of participants is significantly larger or smaller than the number specified in the course syllabus.
- New information or skills need to be added to a course. For example, a group of participants in an IUD skills course needs refresher training in how to perform a pelvic examination.
- Clients are available only at specific times.
- Specific types of clients are available only at specific times.
- The results of the precourse questionnaire or precourse skill assessment indicate a need to emphasize or de-emphasize certain topics, which results in changes to the course schedule.
- Participants must finish early each day because of organizational or institutional commitments.

Note: The schedule and learning activities for a course with a clinical skills component can be adapted or modified only to the extent that client safety is not endangered.

If a course is modified, some parts of the standard learning package (e.g., the course schedule) will need to be revised to reflect the changes. Participants should receive a copy of the new documents on the first day of the course. Other items, particularly the learning guides and checklists, should not be changed for individual courses. **Appendix A** describes the extent to which each document in a learning package should be modified.

Reviewing the information in this appendix should convince most trainers that adapting a course is not an easy task and requires considerable time and effort. Furthermore, the trainer should resist efforts to change a course if it appears that doing so will have a negative impact on the quality of training. Lowering the level of knowledge, attitudes and skills acquired by participants endangers the safety of clients encountered during training as well as those who will be served in the future.

CLASSROOM SELECTION AND ARRANGEMENTS

Situation 3: You arrive early on the first day of the course. You find that the classroom is large enough, but contains only chairs. There are no tables or audiovisual equipment in the room. Outside of the room there is a table for registration, but you see no area for the morning tea break. What could have prevented this problem? What should you do right now?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

The classroom for a group-based course is usually located in one of two sites:

- close to, or in the same building as, the clinic where the clinical portion of training will be held; or
- in a hotel where the participants are staying.

In choosing a site, the clinical trainer should make sure that:

- This course is the only event scheduled in the room for the entire time period (e.g., 10-day course) to avoid moving equipment, packing up models and removing flipchart pages from the walls at the end of each day.

- The space is large enough for the number of participants. The classroom should be large enough to accommodate:

    - Tables arranged in a U-shape or other formation that will allow as many of the participants as possible to see one another and the trainer (this may be difficult in a lecture hall where chairs are attached to the floor)

    - A table in the front of the room where the trainers can place their course materials

  - Space for audiovisual equipment (e.g., flipchart, screen, overhead projector, video player, monitor); the trainer should make sure that participants will be able to see the projection screen and other audiovisuals

  - Space for participants to work in small groups (i.e., either arrange chairs in small circles or work around the tables), unless separate breakout rooms (see below) are available

  - Space to set up simulated clinics (e.g., for activities with anatomic models or counseling practice)

- Breakout rooms for small group work (e.g., case studies, role plays, problem-solving activities) are available if necessary, and are set up with tables, chairs and any materials that the participants will need.

- The room is properly heated or cooled and ventilated.

- There will be adequate electric power throughout the course, and contingency plans have been made in case the power fails.

- There are toilet facilities which are adequately maintained.

- Telephones are accessible and in working order, and emergency messages can be taken.

- Furniture such as tables, chairs and desks is available. The chairs are comfortable and tablecloths are available.

- There is a writing board with chalk or marking pens, as well as an information board available for posting notes and messages for participants.

- The lighting is adequate, and the room can be darkened enough to show audiovisuals and still permit participants to take notes or follow along in their learning materials.

- There is audiovisual equipment in working order, with spare parts such as bulbs readily available. The video monitor is large enough so that all participants can see it well. There are sufficient electrical connections, and extension cords, electrical adaptors and power strips (multi-plugs) are available, if necessary.

- A video camera is available to record participant presentations during the course, if applicable (i.e., for a clinical training skills course).

There are also other arrangements related to the training site which the trainer needs to consider:

- Refreshments for morning and afternoon breaks should be planned. Decide if these breaks will be set up in the classroom, outside of the classroom or in another room (e.g., cafeteria).

- The trainer may need to plan for meals. Decide if these meals will be set up in the classroom, outside of the classroom or in another room (e.g., cafeteria).

- The training room should be set up on the day before the course begins.

CLINIC SELECTION AND ARRANGEMENTS

Situation 4: On the third day of the course, you take the 12 participants for a tour and introduction to the staff of the clinic where they will have their practice sessions. You meet the clinic supervisor and learn not only that staff did not know that you and your participants were coming, but that there will probably be an insufficient number of clients with whom the participants can work. What could have prevented this problem? What should you do right now?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

The key to the success of the clinical practice sessions is to begin planning for them as early as possible. The effort expended in identifying the strengths and weaknesses of the site(s) and developing a relationship with the staff will be paid back many times over when the participants have clinical experiences that allow them to become competent, or even proficient, in the skills they need to complete the course successfully.

The clinical trainer may be asked to select or assist in the selection of clinical training sites. The pertinent information to collect in this regard is detailed below. If a site has already been selected, the trainer must visit the site(s) well before the course begins and review this same information in order to determine if the facility is capable of providing the clinical practice required.

- **Adequate client caseload.** Will there be clients requesting the family planning service for which training is being conducted? The number

of clients should be sufficient to provide all participants adequate opportunities for counseling as well as service provision. A good client mix will allow participants additional clinical and problem-solving experience. If no single site has enough clients to accommodate all the participants, it may be necessary to divide them into smaller groups which go to different sites. **A clinical trainer skilled in the clinical procedure being learned must be present at each clinical site for each clinic session.**

- **Adequate space.** The clinical training site should be able to accommodate the participants and trainer(s) without sacrificing the quality of services. This includes being sure that clients, staff and participants can move through the clinic without impeding client flow and service provision. Dividing the participants into smaller groups and using a number of sites will avoid overcrowding one clinic but will, of course, require additional clinical trainers to accompany each group.

- **Adequate supplies.** Clinical facilities must have enough instruments and supplies to provide services to clients on an ongoing basis. It may be necessary to supplement the clinic's basic supplies of consumable items (e.g., chlorine bleach) or to provide additional instruments needed for the procedure. This must be planned for and supplies procured before the course begins.

- **Appropriate service provision practices.** It is critical that the site already be providing services, including counseling and recommended infection prevention practices, in a manner consistent with what will be taught and practiced. While it may not always be possible to use sites that follow these procedures exactly, it is best to use clinics with practices that are as similar to them as possible. This will make the trainer's job as coach easier because the staff can serve as role models for participants and will be able to guide them in their practice. The participants will feel more comfortable if what they are learning is supported by what they see happening around them in the clinic.

- **Sites similar to where the participants work.** Using sites similar to where the participants work makes the learning situation more real for them and demonstrates that what they are learning can actually be put into practice in their own work sites.

- **Staff who are receptive to having the participants.** Most clinic staff are open to the idea of participants coming to their work site to apply new skills—they have been in that situation themselves and may be

again. If staff are opposed to hosting participants, it is best not to use these sites because negative staff attitudes will undermine the creation of a positive learning environment.

Few clinic sites will meet all of these criteria. One of the most challenging issues will be differences in how services are routinely provided in the clinic and the standardized procedures and practices being taught in the course. The clinical trainer should work with the staff, explaining how the **learning guides** and **checklists** were developed and why the steps and tasks outlined are the safest and most efficient way to

provide services, for both clients and clinicians. It probably will not be possible to change service provision practices immediately, but the trainer should make sure that the staff understands that the participants will be required to follow the checklists. The trainer should reassure the staff that the **clinical trainer will be there to supervise** the participants and make certain that clients are served safely and promptly.

Developing a good relationship with the staff will allow the clinical trainer to help overcome some of the other problems that may exist (e.g., lack of supplies to accommodate the additional staff in the clinic). The staff needs to know the objectives of the clinical experience, who the participants are and what they are capable of doing. This knowledge will help the staff to understand and carry out, as effectively as possible, its role in training and supervising the participants.

Setting a good example for the staff is extremely important. It will take time and effort on the part of the clinical trainer, but every change that the staff comes to accept will improve the quality of the experience for the participants and the services for the clients. This is one of the most important reasons for beginning preparations for the clinical practice early.

SUMMARY

Many of the problems encountered during a clinical skills course can be avoided through careful planning. Giving thought to participant selection, and then communicating with both those attending and their supervisors, will help to ensure that the appropriate participants are present. Making arrangements concerning classroom and clinical facilities is the next critical step in planning the course. Reviewing the course materials and adapting them as necessary are also key components of the planning process. When the training course begins, the trainer will find that this careful planning was well worth the effort, and has helped to create an environment where the successful transfer of knowledge, attitudes and skills can occur.

SITUATION RESPONSES

Situation 1 This is a common problem and one that is not easily handled. Ideally, the trainer should approach the participant and try to determine why the individual is attending the course. What is the participant's understanding of why s/he was selected and what s/he is expected to do as a result of attending the course? If it appears that there has been a misunderstanding and that the individual is able to leave the course without embarrassment, this is the ideal situation.

If, due to any number of circumstances, the individual must remain in the course, make it very clear to the participant (and her/his supervisor if possible) that this person will not in any way endanger clients or impede the progress of the course. This participant should receive a "statement of participation" as opposed to a "statement of qualification" when participants in the course are being qualified as service providers.

Situation 2 This is a very common and challenging situation for the clinical trainer. The model course design calls for a specific number of days needed to deliver a course. When you receive a request to modify the course schedule you will have to consider a number of factors (presented in this chapter). The primary issue is the point at which client safety becomes a concern because participants are unable to achieve all of the course objectives. Although it may be easy to conduct the course in 9 days, it becomes more difficult when it becomes 8, 7 or fewer. If you feel that the quality of the shortened course will jeopardize client safety, do not conduct the course!

Situation 3 This problem could have been prevented by talking with someone at the training site in advance and explaining specific needs with regard to room furniture and its arrangement, audiovisual equipment, plans for breaks and meals and many other items presented in this chapter. Arriving early and checking on arrangements the evening before the course will also help to prevent these types of problems.

The best solution at this point is to quickly arrange the room as well as you can before the participants arrive, using whatever furniture you can locate easily. Start the course on time and explain the problem to the participants. At the first tea or lunch break, find out what other furniture and equipment, if any, is on the premises and can be brought to your classroom. Continue working on these arrangements at the next break or at the end of the day. If possible, find someone at the site to assist with locating tables and audiovisual equipment, either on the premises or elsewhere, and bringing them to the classroom.

Situation 4 This is a major problem and could have been avoided if the trainer or faculty member had visited the site in advance, talked with the supervisor, toured the clinic and discussed course objectives, number of participants, client caseload and related matters.

Given that the course is underway, there are several alternatives. First and foremost, apologize to the supervisor and explore any alternatives within that clinic. Second, consider looking for another clinic site (which may require additional transportation and an additional clinical trainer). Third, consider dividing the participants into two groups. One group can work in the clinic while the others practice in the classroom (e.g., working with models, participating in role plays).

SAMPLE 2-1

TRAINER'S CHECKLIST FOR CLINICAL TRAINING COURSE PREPARATION

KEY PREPARATION STEPS	✔ WHEN COMPLETE	COMMENTS
Participant Selection and Management		
Review participant selection criteria in course syllabus		
Visit the potential participants in their clinical sites (if possible)		
Clarify responsibility for participant transportation to and from the course		
Arrange participant transportation to and from the clinical training sites		
Clarify housing arrangements		
Clarify per diem rates (if applicable)		
Clarify housing costs		
Provide the participants with the phone and fax numbers of the training site and/or person making arrangements, if appropriate		
Classroom Logistics		
Consider issues of cost and proximity to work and clinic when selecting a site		
Ensure that the classroom is sufficiently large and has good light and ventilation		
Ensure that the required audiovisual equipment is available		
Arrange for breakout rooms, if applicable		
Arrange for breaks and meals, if applicable		
Arrange to set up the room the day before the course begins		
Make sure the furniture is arranged appropriately		

KEY PREPARATION STEPS	✔ WHEN COMPLETE	COMMENTS
Clinic Logistics		
Ensure adequate number of clients		
Ensure that there is adequate space in the clinic		
Ensure that adequate supplies are available		
Ensure that appropriate service provision practices are being followed		
Ensure that clinic staff are aware that individuals in training will be working in the clinic and that they are aware of the course objectives		
Classroom Preparation		
Review the course syllabus		
Review the course outline		
Review the course schedule		
Review the learning guides and checklists		
Review the pre- and midcourse questionnaires		
Study the reference manual		
Prepare presentation notes		
Prepare supporting audiovisuals		
Check all audiovisual equipment		
Prepare anatomic models, instruments and other equipment		
Practice clinical procedures with models		

SAMPLE 2-2

MATERIALS NEEDED FOR A 2-WEEK IUD TRAINING COURSE

Supplies and Equipment

- Flipchart easels (2)
- Flipchart pads (5–6)
- Flipchart pens (3 boxes)
- Masking tape (3 rolls)
- Name tents (1 for each participant, clinical trainer, observer, etc.)
- Transparency film (3 boxes of 100 of either the film used in the copy machine or boxes of plain acetate sheets)
- Transparency pens (4 sets of nonpermanent pens)
- Overhead projector with an extra bulb
- Screen
- Videotape player and monitor
- Extension cords (2)

Learning Materials

- Reference Manual (1 for each participant and trainer)
- Participant's Course Handbook (1 for each participant)
- Trainer's Notebook (1 for each trainer)
- Course certificates
- Video(s)
- Anatomic models
  - ZOE pelvic model (1 for every 3 participants)
  - Hand-held uterine model (1 for each participant, if possible)
- IUD insertion and removal kits (1 for each ZOE pelvic model)
- IUDs in sterile packages (2 for each participant)
- Supplies
  - Bleach
  - Buckets
  - Gloves
  - Drapes for models
  - Cotton or gauze

SAMPLE 2-3

COURSE SYLLABUS FROM AN IUD TRAINING COURSE

Course Description. This 2-week (10 to 12 days) clinical training course is designed to prepare the participant to counsel individuals concerning the use of IUDs as a contraceptive method and to become competent in inserting and removing the Copper T 380A IUD and in managing side effects and other health problems associated with the use of IUDs.

Course Goals

- To influence in a positive way the attitudes of the participant toward the benefits and appropriate use of IUDs
- To provide the participant with general counseling skills as well as special training in method-specific counseling for IUDs
- To provide the participant with the knowledge and skills needed for Copper T 380A IUD insertion and removal
- To provide the participant with the knowledge and skills needed to manage side effects and health problems related to IUD use
- To provide the participant with the knowledge and skills needed to organize and manage quality IUD services

Participant Learning Objectives

By the end of the training course, the participant will be able to:

1. Counsel a client interested in using the Copper T 380A IUD as a contraceptive method.
2. Explain how the Copper T 380A IUD prevents pregnancy and its most common side effects.
3. Explain the indications and precautions for using a Copper T 380A IUD.
4. Perform a client assessment, including a limited medical history and a physical examination.
5. Screen a client for sexually transmitted genital tract infections (GTIs) and perform simple microscopic tests, if equipment is available.
6. Use recommended infection prevention practices which minimize the risk of postinsertion/postremoval infections and transmission of serious diseases, such as hepatitis B and/or HIV/AIDS to clients and healthcare staff.
7. Load the Copper T 380A IUD inside the sterile package without using high-level disinfected or sterile gloves.
8. Insert the Copper T 380A IUD gently and safely using a no-touch insertion method.
9. Provide counseling to the client following IUD insertion.
10. Provide followup management of the client with an IUD, including appropriate management of side effects and other health problems.
11. Explain the indications for when to remove the Copper T 380A IUD.
12. Remove a Copper T 380A IUD from a client.
13. Explain how the quality of care process can be used to improve and maintain high quality, client-oriented IUD services.
14. Describe the skills needed to organize and manage high quality IUD services.

Learning Methods

- Illustrated lectures and group discussions
- Individual and group exercises
- Role plays

- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (counseling and IUD insertion and removal)

Learning Materials. This course handbook is designed to be used with the following materials:

- Reference manual: ***IUD Guidelines for Family Planning Service Programs***, 2nd ed. (JHPIEGO)
- Videotape: ***Insertion and Removal of the Copper T 380A IUD*** (JHPIEGO)
- Infection prevention videotape: ***Infection Prevention for Family Planning Service Programs*** (AVSC and JHPIEGO)
- IUD insertion and removal kits and Copper T 380A IUDs in sterile packages
- Pelvic and hand-held uterine models

Participant Selection Criteria

Participants for this course should be clinicians (physicians, nurses or midwives) working in a healthcare facility (clinic or hospital) that provides women's health services.

Methods of Evaluation

Participant

- Precourse Assessment Checklist for IUD Counseling and Clinical Skills (to be completed by clinical trainer)
- Pre- and Midcourse Questionnaires
- Learning Guides and Practice Checklist for IUD Counseling and Clinical Skills
- Checklist for IUD Counseling and Clinical Skills (to be completed by clinical trainer)

Course

- Course Evaluation (to be completed by each participant)

Course Duration

- Twenty sessions in a 2-week (10–12 day) sequence

Suggested Course Composition

- 10 health professionals (clinicians) or 5 teams[2]
- 2 clinical trainers
- 1 counseling or infection prevention or clinic management trainer

[2] The course size will be limited by the available space (classroom and demonstration room/areas) at the training facility and the number of potential IUD clients per session at the clinical training site(s).

THREE

CREATING A POSITIVE LEARNING CLIMATE

INTRODUCTION

The environment within which learning occurs has a tremendous impact on the quality of the learning experience. A positive learning climate maximizes the effectiveness of various learning methods, and thereby helps participants to achieve the course objectives.

Good planning, before training begins, is necessary to creating a positive learning climate. Because the **clinical trainer sets the tone** for the course, how the trainer delivers information is the key to establishing and maintaining a positive learning climate during training. In any course, **how** something is said may be just as important as **what** is said. To help create and maintain an atmosphere that is conducive to learning, the trainer must understand how people learn and how groups develop, and be able to use effective presentation skills.

Chapter Objective

After completing this chapter, the participant will be able to create a positive learning climate.

Enabling Objectives

To attain the chapter objective, the participant will:

- Identify characteristics of how people learn
- Explain how groups form and develop
- Use effective presentation skills
- Introduce a presentation
- Use questioning techniques
- Summarize a presentation

HOW PEOPLE LEARN

Situation 1: You have been selected to attend an IUD clinical skills course and you are both excited and nervous about the course. When you arrive at the classroom, a number of the other participants are already there and you do not know any of them. As you take a seat the trainer arrives and begins describing her clinical background. After about 20 minutes of listening to her talk, you are very apprehensive and wonder if you made a mistake in attending the course. Why are you feeling so nervous about this course? What would you suggest that the trainer do differently to relieve your uneasiness?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

Establishing a positive learning climate depends on understanding how adults learn. The clinical trainer must have a clear understanding of what the participants need and expect, and the participants must have a clear understanding of why they are there. Adults who attend courses to acquire new knowledge, attitudes and skills:

- Require learning to be **relevant**
- Are highly **motivated** if they believe learning is relevant
- Need **participation** and **active involvement** in the learning process
- Desire a **variety** of learning experiences
- Desire **positive feedback**
- Have **personal concerns** and need an atmosphere of safety
- Need to be recognized as **individuals** with unique backgrounds, experiences and learning needs
- Must maintain their **self-esteem**
- Have **high expectations** for themselves and their trainer
- Have **personal needs** that must be taken into consideration

These ten characteristics are described in more detail below.

Relevance

The clinical trainer should offer participants learning experiences that **relate directly to their current or future job responsibilities**. At the beginning of the course, the objectives should be stated clearly and linked to job performance. The clinical trainer should take time to explain how each learning experience relates to the successful accomplishment of the course objectives.

Motivation People bring **high levels of motivation and interest** to learning. Family planning workers, for example, may wish to acquire new knowledge and skills to improve client services. Motivation can be increased and channeled by the clinical trainer who provides clear learning goals and objectives. To make the best use of a high level of participant interest, the clinical trainer should explore ways to incorporate the needs of each participant into the learning sessions. This means that the trainer needs to know quite a bit about the participants, either from studying background information about them or by allowing participants to talk early in the course about their experience and learning needs.

Involvement Few individuals prefer just to sit back and listen. The effective clinical trainer will design learning experiences that **actively involve the participants in the training process**. Examples of how the clinical trainer may involve participants include:

- Allowing participants to provide input regarding schedules, activities and other events
- Questioning and feedback
- Brainstorming and discussions
- Hands-on work
- Group and individual projects
- Classroom activities

Variety Participants attending courses **desire variety**. The clinical trainer should use a variety of learning methods including:

- Audiovisual aids
    - writing boards
    - flipcharts
    - overhead transparencies
    - slides
    - videotapes
    - anatomic models and real items (e.g., instruments)
- Illustrated lectures
- Demonstrations

- Brainstorming
- Small group activities
- Group discussions
- Role plays and case studies
- Guest speakers

Positive Feedback

Participants need to know **how they are doing**, particularly in light of the objectives and expectations of the course. Is their progress in learning clinical skills meeting the trainer's expectations? Is their level of clinical performance meeting the standards established for the procedure? **Positive feedback provides this information.**

Learning experiences should be designed to move from the known to the unknown, or from simple activities to more complex ones. This progression provides positive experiences and feedback for the participant. To maintain positive feedback, the clinical trainer can:

- Give verbal praise either in front of other participants or in private
- Use positive responses during questioning:
  - "That's correct!"
  - "Good answer!"
  - "That was an excellent response!"
- Recognize appropriate skills while coaching in a clinical setting:
  - "Very good work! Ilka is holding the scalpel in a way that provides excellent control."
  - "I would like everyone to notice the incision that Jean Robert just made. He did an excellent job, and your incisions should look like this one."
- Let the participants know how they are progressing toward achieving learning objectives

Personal Concerns

The clinical trainer must recognize that many participants fear failure and embarrassment in front of their colleagues. Participants often have concerns about their ability to:

- Fit in with the other participants

- Get along with the trainer
- Understand the content of the training
- Perform the skills being taught

The clinical trainer must be aware of these concerns and open the course with an introductory activity that will place participants at ease. It should communicate an **atmosphere of safety** so that participants do not judge one another or themselves. For example, a good introductory activity is one which acquaints participants with one another and helps them to associate the names of the other participants with their faces. This opening activity can be followed by learning experiences that support and encourage the participants.

Being Treated as an Individual

People want to be **treated as individuals**, each of whom has a unique background, experience and learning needs. A person's past experiences are good foundations upon which the clinical trainer can base new learning.

Each person is the best judge of what ideas and skills are relevant to her or his particular work situation.

To help ensure that participants feel like individuals, the clinical trainer should:

Use participant names as often as possible

- Involve all participants as often as possible
- Treat participants with respect
- Allow participants to share information with others during classroom and clinical instruction

Self-Esteem

Participants need to **maintain high self-esteem** to deal with the demands of a clinical training course. Often the clinical methods used in training are different from clinical practices used in the participants' clinics. It is essential that the clinical trainer show respect for the participants, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires the trainer to:

- reinforce those practices and beliefs embodied in the course content;
- provide corrective feedback when needed, in a way that the participants can accept and use it with confidence and satisfaction;

- provide training that adds to, rather than subtracts from, their sense of competence and self-esteem; and

- recognize participants' own career accomplishments.

High Expectations

People attending courses tend to set **high expectations both for the trainers and for themselves**. Getting to know their clinical trainers is a real and important need. Clinical trainers should be prepared to talk modestly, and within limits, about themselves, their abilities and their backgrounds.

Personal Needs

All participants have **personal needs** during training. Taking timely breaks and providing the best possible ventilation, proper lighting and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.

The challenge for the clinical trainer is to acknowledge all of the participants' desires, needs and concerns and at the same time help the individuals come together as a group. By sharing with the participants expectations of how they will behave during the course, and asking them to tell the group their own expectations, the trainer begins the process of establishing patterns of behavior acceptable to the group, or **group norms**. This step is critical in creating a positive learning climate.

UNDERSTANDING GROUP DYNAMICS

Situation 2: You are a new clinical trainer and you want the participants to approve of you. The first day of the clinical skills course, two participants from the same province arrive late and join the group after the introductions and review of the day's agenda. For the next 2 days, they continue arriving late each morning, as well as after tea and lunch breaks. By the third day, other participants are joining the pair in arriving late. You are growing concerned and are wondering what you should do. What are your options in dealing with the individuals? What are your options in dealing with the "time issue" in the group?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

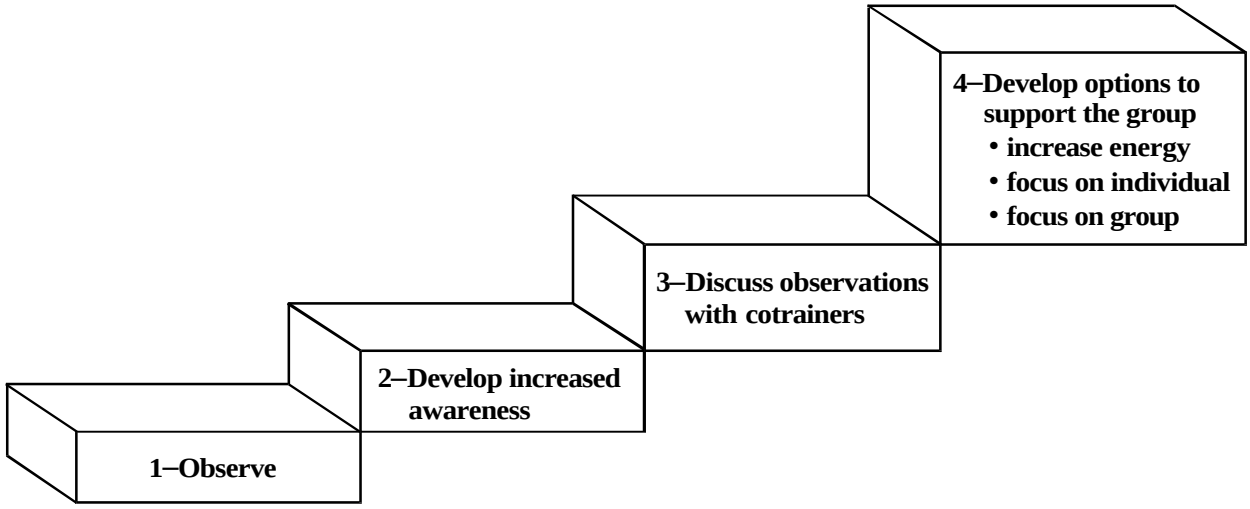
From the previous section on adult learning, it is clear that establishing a positive learning climate depends on the individual participants coming together to form a healthy, mutually supportive group. A collection of individuals becomes such a group when:

- they share a **common purpose**,

- the members **think of themselves as a group** and they share a common experience in attending the course,
- each member's contributions and questions are **valued and respected**,
- an **open and trusting climate** develops, and
- the members pay attention to **how they work together**.

These are the forces, known as **group dynamics**, that are present among individuals who come together to form a group. To understand and learn to manage group dynamics, the trainer, without making any judgments, must become acutely aware of what is happening in the training room. Gradually, as shown in **Figure 3-1**, the trainer progresses through several steps—observation, increased awareness, discussion with cotrainers—before developing options to support the group and help it achieve its goals.

Figure 3-1. Steps in Understanding Group Dynamics



While monitoring the development of the group and making choices to guide it, the trainer must also realize that the group functions at several levels—as individuals, as small groups and as the larger group. The dynamics become more complex as the members contribute individually, interact in small groups and then work within the larger group; they are individuals **and** a part of the small group **and** members of the large group. At the same time, the small group unit is bringing its own dynamic to the larger group. Each trainer will find that s/he is most comfortable observing

and understanding the behaviors at one of these levels—individual, small group or larger group. The new trainer must be aware of this, and strive to become adept in working at each level in order to manage group dynamics effectively. One way of developing skills in observing and working at these various levels is to use a training journal.

Using a Training Journal

A new trainer conducting courses often finds it difficult to be aware of everything happening in the training room. One way to improve observation skills is to keep a training journal. The trainer should take 30–45 minutes after each training day to make notes as described below.

- Identify a specific incident that stands out for you.

  Examples:
  One participant was particularly helpful in encouraging her group to complete its task.
  A participant challenged your technical knowledge about the IUD.
  At a particular time during the morning, the group fell totally silent and tension started to build in the room.
  You have noticed that participants are deferring to a senior Ob/Gyn participant who does not like "all this interactive nonsense."

- Record this incident in as much detail as possible, identifying what each person in the exchange said or did.

- Write what you were doing (if anything) during the incident.

- Write what you were thinking.

- Record what you were feeling. This step is extremely important because often our feelings will give us information about a situation that our analytical minds cannot give.

- After all the thoughts and feelings are recorded, ask yourself this question: "What can I learn from this incident?" There are times when an answer will immediately present itself. At other times, you may have to wait a while for an idea. If nothing comes to you, leave it and come back to it later, or leave it completely.

- Note on what level you make your observations: individual, small group or total group.

- Over time, if you look back at what you have written, you can begin to identify patterns in your learning. Sharing these patterns with other trainers will help strengthen your observation skills and support other trainers in further developing their skills.

What the Group Does (Content) and

In monitoring group development, the trainer attends to the **content** as well as the **process** in the group. When the group is discussing how adults learn or how to give an effective presentation, their focus is on **content**.

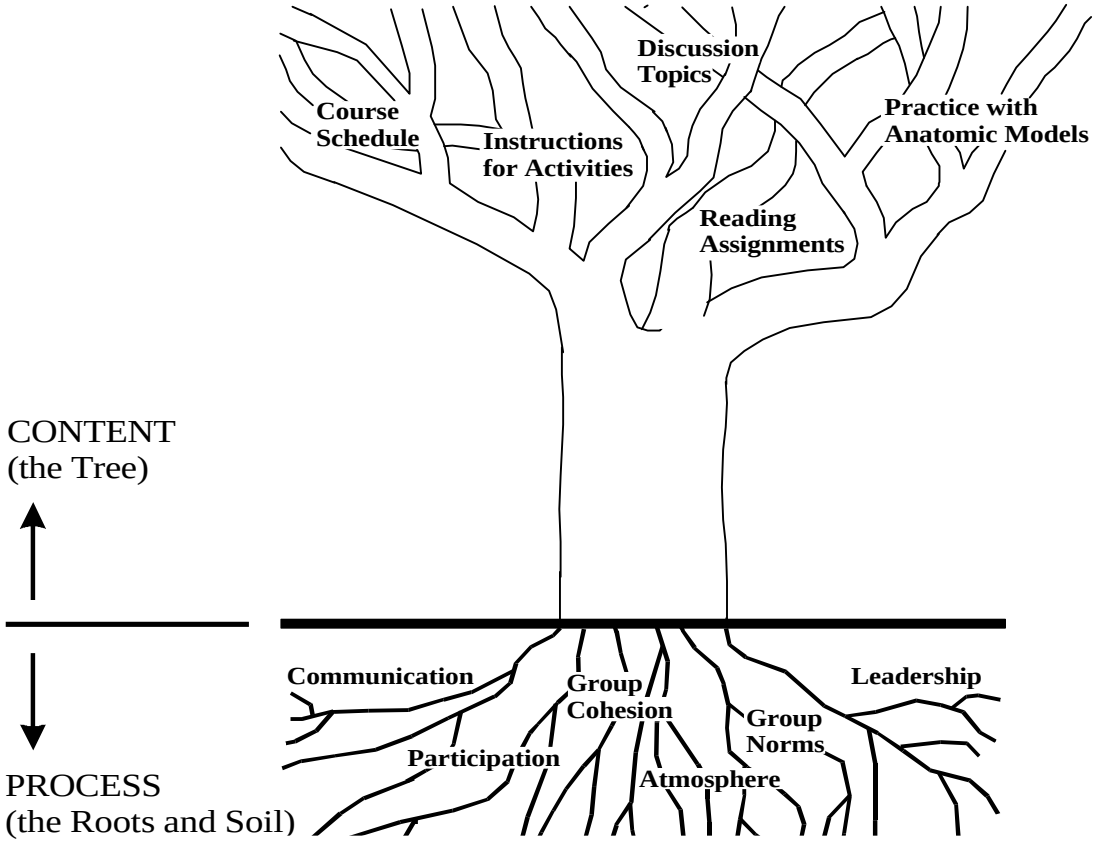
How It Does It (Process)

Figure 3-2 depicts the group as a tree and its roots. The content in the group is the part of the tree above the soil: the trunk and branches.

In a training course, the content is determined before the course begins. It is described in the course objectives and further refined during each session. For an individual training session, the content or "tree" includes the course schedule, agenda for the day, written or verbal instructions for small group activities, readings from the reference manual, topics for discussion and the learning goals for each topic and activity. The challenge for the clinical trainer is to make sure that all required course content is covered and that the course objectives are met.

When the individuals in the course are working together as a group, their interaction is known as group **process**. The process or interaction in the group is depicted in the figure by the root system of the tree and the soil which supports the roots. Since the root system is below the surface, it is more difficult to see and understand. Similarly, it is sometimes difficult for trainers to observe group interaction until they know what behavior patterns they are seeking. **Managing the group process is as important for the trainer as managing the content of the course.**

Figure 3-2. Content and Process: The Tree and Its Roots



Why is it important for the clinical trainer to understand group process? For the training group to move toward its learning goals, it needs three important elements:

- structure,
- direction, and
- leadership.

Without these elements, the group may begin to disintegrate, and undesirable group behavior that will hinder learning may emerge. But with these elements in place, the healthy group described above can develop. Understanding what to look for will help the clinical trainer know when to intervene if the group begins to develop any unhealthy patterns (e.g., arriving late, ridiculing other participants, talking during a presentation). The trainer can also intervene in the group in order to reinforce positive, healthy group behavior. **Table 3-1** shows aspects of group process that the trainer and participants should observe, gives examples of both positive and negative behaviors that the trainer should watch for and suggests steps the trainer can take when undesirable behavior occurs.

Table 3-1. Group Process: Behaviors and Interventions

ASPECT OF GROUP PROCESS	DESIRED BEHAVIOR	EXAMPLES OF UNDESIRABLE BEHAVIORS	POSSIBLE
Communication	When participants speak, other group members listen and respond appropriately. Participants are aware of how communication is happening in the group.	Participants interrupt one another or the trainer. Group members do not listen to one another. Participants look at the floor when they talk. Participants carry on side conversations.	The trainer asks group member communicating: "Do you see a are communicating?" When there are side conversati who are involved in it, or asks the group: "What does it feel li talking at the same time?"
Participation	Discussion is structured so that everyone can participate.	Some participants dominate discussion. A few participants are uncomfortable talking in a group. The trainer talks too much.	When dominant members wan hear from some other people." The trainer is sensitive in draw The trainer monitors the amou is the key.
Group Cohesion	Members accept group goals and are willing to work toward them.	There is competition between individuals or subgroups working on a task.	The trainer calls the group's at explains to them that some deg the group interaction. The trai rewards for everyone and enou
Atmosphere	Group members are friendly with one another and feel free to express themselves and share personal feelings.	Group members are formal in their interactions. Atmosphere is tense.	The trainer asks the group, "W now?" If the group is silent, th and asks for comments from pa If the atmosphere is tense, the of tension on the group. If tens discuss the issue and resolve it
Group Norms	The group has developed a consensus about how to work together.	Participants arrive late. Participants talk at the same time. Sessions do not end on time. Feedback is insincere.	Discuss norms on the first mor trainer must discuss this issue the front of the room the flipch the first day, and ask the group committed to following the no
Leadership	The trainer respects the participants and speaks to them as colleagues, and the participants respect the trainer.	The trainer speaks to the participants in a condescending way. The trainer is not comfortable in a leadership role. The trainer discourages discussion that disagrees with her/his opinion.	The trainer has to take respons there are two or more trainers, training alone, the trainer arran trainer who will provide feedb observed will have to make cle believes she needs feedback.

As a result of the interactive methods used and the trainer's management of the group process, a group identity gradually emerges. The members of the group see themselves as different from most of the traditional teachers they had in the past, and their experience tells them that this way of training is far superior to the old ways. As they get to know one another in the interactive sessions, participants begin to view the others with respect and value their contributions and questions. This results in an open and trusting climate in which participants can learn.

With practice, the effective clinical trainer becomes confident—about both the course material being presented and the status of the group interaction. Knowing when to intervene in the group life and when to stand back is a skill that is developed over time. Knowing how to gauge the energy of the group and how to keep the group moving forward also are skills that are acquired with experience. Each learning event provides additional information about which techniques are effective and which are not. When the trainer uses this experience as a training tool for new trainers, the training room indeed becomes a living laboratory where everybody learns and benefits. A critical factor in keeping the group energy alive and moving forward is the trainer's ability to present the course material in a number of different ways that will keep the participants engaged.

USING EFFECTIVE PRESENTATION SKILLS

Situation 3: You are attending a Norplant implants training course. One of the trainers is giving a presentation on Norplant implants' mechanism of action. Since you are hoping to become a trainer someday, you pay close attention to how the presentation is being delivered. You see that the trainer is looking very closely at a set of notes (on paper, transparencies and flipchart), is talking loudly enough using a constant volume level, is moving around the left side of the room and is asking many questions to those participants on the right side of the room. What are some effective presentation skills this trainer is using? What suggestions for improvement would you offer this trainer?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

There are a number of general presentation skills which can be used to make a training session more effective. These techniques can be used with several different types of presentation (e.g., illustrated lecture, discussion, case study, clinical demonstration). The skilled clinical trainer uses a variety of techniques to involve participants, maintain interest and avoid a repetitive presentation style. Some common techniques are listed below.

- **Follow a plan and use trainer's notes**, which include the session objectives, introduction, body, activity, audiovisual reminders, summary and evaluation.

- **Communicate in a way that is easy to understand.** Many participants will be unfamiliar with the terms, jargon and acronyms of a new subject. The clinical trainer should use familiar words and expressions, explain new language and attempt to relate to the participants during the presentation.

- **Maintain eye contact with participants.** Use eye contact to "read" faces. This is an excellent technique for establishing rapport and getting feedback on how well participants understand the content.

- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone and inflection to maintain participants' attention. Avoid using a monotone voice, which is guaranteed to put participants to sleep!

- **Avoid the use of slang or repetitive words, phrases or gestures** that may become distracting with extended use.

  Examples:

  "OK, now...."
  "Is that clear?"
  "Do you see what I'm saying?"
  Hands in pockets, pacing or rocking on heels.

- **Display enthusiasm about the topic and its importance.** Smile, move with energy and interact with participants. The trainer's enthusiasm and excitement are contagious and directly affect the enthusiasm of the participants.

- **Move around the room.** Moving around the room helps ensure that the trainer is close to each participant at some time during the session. Participants are encouraged to interact when the clinical trainer moves toward them and maintains eye contact.

- **Use appropriate audiovisual aids** during the presentation.

- Be sure to ask both **simple and more challenging questions**.

- **Provide positive feedback** to participants during the presentation.

Examples:

"Very good point, Ilka!"
"Thanks for sharing that story."
"Anne Marie has made an excellent comparison!"

- **Use participants' names as often as possible.** This will foster a positive learning climate and help keep the participants focused on the presenter.

  Examples:

  - During questioning and when providing positive feedback
  - When referring to comments previously made by participants

- Display a **positive use of humor** related to the topic.

  Examples:

  - Cartoons on transparency or flipchart
  - Humorous stories
  - Cartoons for which participants are asked to create captions

- **Provide smooth transitions between topics.** Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, participants may become confused and lose sight of how the different topics fit together into a bigger picture. The clinical trainer must ensure that the transition from one topic to the next is smooth. This can be accomplished by:

  - A brief summary
  - A series of questions
  - Relating content to practice or using an application exercise (case study, role play, etc.) before moving on to the next topic

- **Be an effective role model.** The clinical trainer should be a positive role model in dress, appearance, enthusiasm for the training course, being on time and finishing at the scheduled time.

INTRODUCING A PRESENTATION

Situation 4: You are a participant who is attending a clinical training skills course in order to learn how to be a clinical trainer. One of the other participants is making a presentation and you have been asked to observe the introduction carefully. The participant begins the introduction by asking several questions. After about 10 minutes of discussion related to the questions, the participant shares the objectives and moves into the presentation. What aspects of the introduction went well? What suggestions would you offer for improving this introduction?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

The first few minutes of any presentation are critical. Participants may have their minds on other matters, be unclear what the session is about or have little interest in the topic. The introduction should:

- Capture the interest of the entire group and prepare participants for the information to follow
- Make participants aware of the clinical trainer's expectations
- Help foster a positive training climate

Using a Variety of Introductory Techniques

The clinical trainer can select from a number of techniques to provide variety and ensure that participants do not become bored. Many introductory techniques are available, including:

- **Reviewing the objectives.** Introducing the topic by a simple restatement of the objectives keeps the participants aware of what is expected of them.

  Example:

  "This afternoon we will learn how to use the training arm model for Norplant implants. Our objective is to insert Norplant implants in the training arm using the standard insertion technique. Any questions before we begin?"

- **Asking a series of questions about the topic.** The effective clinical trainer will recognize when participants have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow participants to respond,

discuss answers and comments, and then move into the body of the presentation.

Examples:

"Can someone give us an example of an important infection prevention practice?"

"Silvia, the next topic in our Norplant implants course is client assessment. What are some of the questions we should ask the client?"

"Jose, this is a slide showing the floor plan of a family planning clinic. There are at least three problems related to client flow. Can you identify one of them?"

- **Relating the topic to previously covered content.** When a number of presentations are required to cover one subject, relate each presentation to previously covered content. This helps the participants understand the continuity of the presentations and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.

  Example:

  "When we finished yesterday we were discussing the no-touch technique for IUD insertion. Today, I will answer Mary's question by reviewing why there is no need for prophylactic antibiotics with IUD insertion when the no-touch technique is used."

- **Sharing a personal experience.** There are times when the clinical trainer can share a personal experience in order to create interest, emphasize a point or make the topic more job-related. Participants enjoy hearing these stories so long as they relate to the topic and are used only when appropriate.

  Example:

  "Today we will practice the use of the uterine elevator in minilaparotomy. Before we begin, I would like to share with you my first experience performing a minilaparotomy. The client was...."

- **Relating the topic to real-life experiences.** Many training topics can be related to situations most participants have experienced. This technique not only catches the participant's attention but also facilitates learning because people learn best by anchoring new

information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.

Example:

"Our next topic is pre-operative counseling for the minilaparotomy client. Have you ever had a client who was very nervous and anxious? What did she say or do? How did it affect you? Yasmina, tell us how you would feel if you were the client."

- **Using a case study or problem-solving activity.** Case studies or problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.

  Example:

  "Our next topic is the side effects associated with the Copper T 380A IUD. Please read the case study on page three of your course handbook and answer the questions on page four. We will discuss your responses when everyone has finished."

- **Using a videotape or other audiovisual aid.** Use of appropriate audiovisuals can be stimulating and generate interest in a topic.

  Example:

  "Now that we have performed an easy removal of Norplant implants, we'll use the slide set to review a 'difficult' removal procedure. Afterwards, we'll discuss what made this removal different from the standard technique."

- **Using an imaginative transparency.** Clinical trainers should keep a file of topic-related cartoons, signs, slogans, acronyms and similar items. When appropriate, these can generate interest and a few smiles at the same time.

- **Making a provocative statement.** This technique should be used sparingly and with great care. The idea is to make a controversial statement designed to create a reaction. The ensuing discussion will increase interest in the topic to be presented. Be careful, however, not to make a statement that will upset or alienate participants or with which they may agree, because it may have a negative impact on the learning climate.

Example:

"Our topic this morning is infection prevention practices for minilaparotomy. Now, in my opinion, I think that if you are careful

you don't need to follow all of the recommended infection prevention practices. Ramon, what do you think?"

- **Giving a classroom demonstration.** Most clinical training courses involve equipment, instruments and techniques that lend themselves to demonstrations, which generally increase participant interest.

- **Using a content expert.** Speakers with a specific area of expertise often add credibility to a presentation. The clinical trainer must be sure that the speaker is capable of making an effective presentation. When this is the case, the content expert can motivate the participants' interest in the topic.

  Example:

  "This session will review infection prevention practices. To begin our discussion I would like to introduce Sister Ade Wachura, Infection Prevention Specialist for the hospital. Ade will share with us the hospital's recommended infection prevention practices for surgical contraceptive methods. Please join me in welcoming...."

- **Using a game, role play or simulation.** Games, role plays and simulations generate tremendous interest through direct participant involvement, and therefore are useful for introducing topics.

  Example:

  "Today we will discuss staff motivation. What is it? How do we maintain it? To introduce this topic we are going to take a few minutes to play a game called 'I Am a Winner.' Our first step is to divide into four groups...."

- **Relating the topic to future work experiences.** Participants' interest in a topic will increase when they see a relationship between training and their work. The clinical trainer can capitalize on this by relating objectives, content and activities of the course to real work situations.
  Example:

"This afternoon I will demonstrate an infection prevention practice that you use every day in your work. In fact, it is one of the most important things you do...

USING QUESTIONING TECHNIQUES

Situation 5: You are conducting a clinical skills course. During a break, one of the participants approaches you and asks you why you ask so many questions during your classroom and clinical sessions. How would you respond to this question?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

What is a key characteristic of an effective clinical trainer? Which instructional strategy will the best clinical trainers employ? Which techniques will make the training session more interesting? The answer to all of these questions is effective questioning and reinforcement techniques.

The primary purpose of questioning is to encourage the participants to think about the training topic. Most clinical trainers agree that participants often say that they understand the content, but a knowledge or skills assessment may prove otherwise. Effective questioning gives participants an opportunity to think through content and gain a fuller understanding of the concepts being presented.

Involving participants by using questioning will help to maintain interest. This is especially critical when:

- The topic is complex.
- Training sessions are lengthy.
- The topic is not as exciting as the clinical trainer or participants hoped.

Questions can be used at any time to:

- Introduce a topic
- Increase the effectiveness of the training session
- Promote brainstorming
- Supplement the discussion process

Effective Questioning Techniques

Use a variety of questioning techniques to keep participants interested in the session.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some participants may dominate while others may not participate.

  Example:

  "Would someone please tell me why we...?"

- **Target the question to a specific participant by using that individual's name before asking the question.** The participant is aware that a question is coming, can concentrate on the question and respond accordingly. The disadvantage is that once a specific participant is targeted, other participants may not concentrate on the question.

  Example:
  "Jose, can you tell me what would happen if we...?"

- **State the question, pause and then direct the question to a specific participant.** All participants must listen to the question in the event that they are asked to respond. The primary disadvantage is that the participant receiving the question may be caught off guard and ask the clinical trainer to repeat the question.

  Example:

  "What type of instrument are we using today? Rosminah, can you tell us?"

The key in asking questions is to avoid a pattern. The skilled clinical trainer uses all three of the techniques mentioned above to provide variety and maintain the participants' attention.

Additional questioning techniques that the trainer can use to make the session more interesting include:

- **Use participants' names** during questioning. This is a powerful motivator and also helps to keep all participants involved.
- **Repeat a participant's correct response.** This provides positive reinforcement to the participant and allows the rest of the group to hear the response.

Example:

"Juan is correct. The Copper T 380A IUD is now approved for use for up to 10 years."

- **Provide positive reinforcement for responses** to keep the participants interested in the presentation. Positive reinforcement may take the form of praise, displaying a participant's work, using a participant as an assistant or using positive facial expressions, nods or other nonverbal actions.

  Examples:

  "I couldn't have said it better!"
  "Very good answer, Alain!"
  "I like the way you stated that, Aimee."
  "Excellent thinking, Jose."

- **When a participant's response is partially correct**, the clinical trainer should reward the correct portion and then improve the incorrect portion or redirect a related question to that participant or to another participant.

  Examples:

  "I agree with the first part of your answer; however, can you explain...?"

  "You almost have it! Lydia, can you give Virgilio some help?"

  "Rachid is correct. When performing a minilaparotomy, we open the abdomen and the anterior rectus sheath; however, do we perform these in the order Rachid has indicated? Alain, what do you think?"

- **When a participant's response is incorrect**, the clinical trainer should make a noncritical response and restate the question to lead the participant to the correct response.

  Examples:

  "Sorry, Silvia, that's not correct. Let's look at the situation in a different way. Suppose we...."

"That's not quite what I was looking for. Let's go back to our previous session. Dr. Dimiti, think about the effect on the client's blood pressure. Now if we...."

"Maria, let me rephrase the question. What would happen if we were to adjust the...?"

- **When a participant makes no attempt to respond**, the clinical trainer may wish to follow the above technique or redirect the question to another participant. After receiving the desired response, be sure to draw the original participant back into the discussion.

  Example:

  "Jose, can you add any other precautions for IUD use to those that Enrique has listed?"

When **participants ask questions**, the clinical trainer has two options:

- answer the question, or
- respond with another question.

The clinical trainer must draw on personal experience to determine which option is appropriate for each situation. When the question deals with a complex subject or relates to a topic not previously discussed, the clinical trainer may wish to answer the question.

Example:

"That's an excellent question, Alex. In fact, our discussion next hour will focus on postpartum minilaparotomy. To answer your question briefly,..."

Questions based on the topic, however, may be answered best by asking the participant another question.

Example:

"Dr. Ramos, you asked 'when' we use the uterine elevator. Under what circumstances can you do a minilaparotomy without the uterine elevator?"

Two final cautions about questions from participants:

- When unable to answer a question, the clinical trainer should acknowledge it and admit to not knowing the answer. After the

session, the trainer should research the answer and share it during the next session.

- When participants ask questions that will guide the discussion away from the topic, the clinical trainer must decide whether answering the question and allowing the ensuing discussion will be valuable. When participants will benefit, and time permits, the clinical trainer may wish to follow the new line of discussion. If not, the trainer must move the discussion back to the topic.

SUMMARIZING A PRESENTATION

Situation 6: You are attending a clinical training skills course and are planning a classroom presentation. You know you need a summary at the end of your presentation, so you make a note to ask if there are any questions. Answering the questions will serve as your summary. Is this an appropriate summary technique?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

A summary is used to reinforce the content of a presentation and provide a review of its main points. Generally, a summary is used at the end of a presentation. When course topics are complex, however, periodic summaries may be used to ensure that participants understand the material as it is being presented. In addition, summaries can be used effectively before demonstrations or breaks that interrupt the presentation.

The summary should:

- Be **brief**
- Draw together the **main points**
- **Involve** the participants

Many summary techniques are available to the clinical trainer, including:

- **Asking the participants for questions**, thereby giving participants an opportunity to clarify their understanding of the instructional content. This may result in a lively discussion focusing on those points that seem to be the most troublesome.

- **Asking the participants questions** that focus on major points of the presentation.

- **Administering a practice exercise or test** which gives participants an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for discussion by asking for correct answers and explaining why each answer is correct.

- **Using a game to review main points** provides some variety, when time permits. One popular game is to divide participants into two teams, give each team time to develop review questions and then allow each team to ask questions of the other. The clinical trainer serves as moderator by judging the acceptability of questions, clarifying answers and keeping a record of team scores. This game can be highly motivational and can serve as an excellent summary at the same time.

SUMMARY

The environment in which participants learn has a critical impact on the quality of their learning experience. It is the clinical trainer's responsibility to create a positive learning climate so that learning occurs and course objectives are met. Creating this climate requires thought and careful planning. The trainer must first have a clear understanding of how adults learn. In addition, the trainer must understand the dynamics of how groups form and develop during a course, and be able to provide the structure, direction and leadership needed to help the participants become a healthy group. The trainer can sustain a positive climate by using presentation skills that involve participants and engage their interest. Interesting and informative introductions, effective questioning and reinforcement, and concise and interactive summaries are presentation techniques that can make training sessions more interesting, and ultimately more effective, learning experiences. The **Presentation Skills: Self-Assessment Guide** (**Sample 3-1**) can be used to help determine the effectiveness of presentation skills.

SITUATION RESPONSES

Situation 1 It is natural to feel nervous on the first day of a training course, especially when you are unfamiliar with the other participants and the trainer. In fact, it would be highly unusual for a participant **not** to feel somewhat nervous or uneasy. The participant should take some comfort in knowing that all of the other participants are probably experiencing the same feelings.

In this situation, the trainer is focusing on her needs (to share her background) and is not being sensitive to the needs of the participants. The trainer should limit her introductory remarks to about 5 minutes, and then ask the participants to describe the experiences they bring to the group and their expectations for the course. This will help to establish a positive learning climate.

Situation 2 The aspect of group interaction involved in this situation is **group norms**. The new trainer has several options. The trainer can include in the evaluation of the day a comment on the importance of all the group members arriving on time so that the group can adjourn on time. Engaging the group in this discussion will encourage the participants to jointly establish the norms for the group.

Another option would be for the trainer to initiate a discussion about the group norm of arriving and ending on time as an important issue that trainers need to consider. This approach treats the situation as a **training** issue rather than focusing on the failure of some of the participants.

If neither of these options works, the trainer can speak to the participant privately. This is the least desirable approach because it goes against a training norm that any situation that arises in the group should be resolved in the group in order to encourage and maintain an open, safe learning environment. Furthermore, the trainer does not want to set an example in which a difficult situation is dealt with in private. Rather, the trainer should model behavior by dealing with difficult situations openly in the group and thereby helping to create a safe environment for managing problems.

Situation 3 Effective presentation skills include using a set of notes and supporting audiovisuals, projecting your voice, moving around the room and asking questions to encourage interaction. Suggestions for improvement include avoiding looking too much at notes in order to maintain eye contact, using voice inflection to prevent speaking in a monotone, moving around the entire room and asking questions of all of the participants.

Beginning an introduction with a series of questions is an excellent

Situation 4 technique because it will focus the participants' attention on the topic. Following the questions with a clear statement of the objectives will then let the participants know where the presentation is leading. The only suggestion for improvement would be not to get into lengthy discussions around the introductory questions, as this will confuse the learners and reduce the impact of the introduction.

Situation 5 There are many advantages to asking questions during a classroom or clinical presentation. Questions require the participants to think about and apply the information they have learned during the course. Using questions also affords the trainer an opportunity to involve all participants, use their names, provide positive feedback and encourage participants to ask questions. Responses to questions also let the trainer know how effectively information is being transferred to the participants.

Situation 6 Asking the participants for questions is an excellent technique as part of a summary. The trainer, however, should have a few key questions ready in the event there are few or no questions, which often happens, or if an important topic is not addressed by the participants' questions.

SAMPLE 3-1

PRESENTATION SKILLS: SELF-ASSESSMENT GUIDE

To what degree are the following statements true of your actions or behavior when making training presentations?

PRESENTATION SKILL	YES	SOMETIMES	NO
1. I present an effective introduction.			
2. I state the objective(s) of the presentation as part of the introduction.			
3. I ask questions of the entire group.			
4. I target questions to individuals.			
5. I ask questions at a variety of levels.			
6. I use participant names.			
7. I provide positive feedback.			
8. I respond to participant questions.			
9. I use trainer's notes or a personalized reference manual.			
10. I maintain eye contact with participants.			
11. I project my voice so that all participants can hear.			
12. I move about the room.			
13. I use audiovisuals effectively.			
14. I display a positive use of humor.			
15. I present an effective summary.			
16. I provide opportunities for application or practice of presentation content.			

Those presentation skills I feel competent in using include:

Those presentation skills I would like to improve include:

FOUR

USING AUDIOVISUAL AIDS

INTRODUCTION

Using appropriate audiovisual aids is a critical step in the training process. Audiovisual materials supplement learning activities by highlighting important points or key steps or tasks. Because individuals have different styles of learning, using a variety of audiovisuals allows the participant to receive information in different ways and reinforces the learning process.

Before each training session, test all audiovisual equipment to be sure that it is working properly.

Chapter Objective

After completing this chapter, the participant will be able to use audiovisuals effectively in presenting information.

Enabling Objectives

To attain the chapter objective, the participant will:

- Present information using a writing board
- Present information using a flipchart
- Present information using transparencies
- Present information using slides
- Present information using a videotape

WRITING BOARD

A writing board can display information written with chalk (chalkboard or blackboard) or special pens (whiteboard). Although there usually are more effective methods of transmitting information, the writing board is still the most commonly used visual aid. It is especially useful for impromptu discussions, brainstorming sessions and note taking.

The **advantages** of using a writing board:

- Available in most training rooms and does not require electricity
- Easy to use and inexpensive
- Suitable for use by both clinical trainers and participants

- Excellent for brainstorming, problem solving, making lists and other participatory activities

There are some **disadvantages** to using a writing board, including:

- The board cannot hold a large amount of material.
- Writing on the board is time-consuming.
- It is difficult to write on the board and talk to the participants at the same time.
- The board can get messy.
- There is no permanent record of information presented.

Tips for Using a Writing Board

- Keep the board clean.
- Use chalk or pens that contrast with the background of the board so that participants can see the information clearly.
- Make text and drawings large enough to be seen in the back of the room.
- Prepare complex drawings in advance (if very complex, an overhead transparency or 35 mm slide may be preferable).
- Underline headings and important or unfamiliar words for emphasis.
- Do not talk while facing the board.
- Do not block the participants' view of the board; stand aside when writing or drawing is completed.
- Allow sufficient time for participants to copy the information from the board.

FLIPCHART

A flipchart is a large tablet or pad of paper, usually on a tripod or stand. It can be used for displaying previously prepared notes or drawings as well as for brainstorming and impromptu discussions.

Advantages of the flipchart:

- Available in most training rooms, easy to move from room to room and does not require electricity
- Small enough that several may be used simultaneously (e.g., for small group work)
- Easy to use and inexpensive
- Suitable for use by both clinical trainers and participants
- Excellent for brainstorming, problem solving, making lists and other participatory activities
- Pages of information can be prepared in advance and revealed at appropriate points in the presentation
- Pages can be removed from the pad and taped on the walls of the training room for future reference

Disadvantages of the flipchart are the same as those listed for the writing board, except that there is a permanent record of the information presented.

Tips for Using a Flipchart

- Use wide-tipped pens or markers; markers with narrow tips produce printing that is difficult to read.
- Print in block letters that are large enough to be read easily in the back of the room.
- Use different colored pens to provide contrast; this makes the pages visually attractive and easier to read.
- Use headings, boxes, cartoons and borders to improve the appearance of the page.
- Use bullets (•) to delineate items on the page.
- Leave plenty of white space and avoid putting too much information on one page (crowded and poorly arranged information is distracting and difficult to read).

- When pages are prepared in advance, use every other page (if every page is used, colors may show through and make text difficult to read).

- Have masking tape available to hang flipchart pages on the walls during brainstorming and problem-solving sessions.

- To hide a portion of the page, fold up the lower portion of the page and tape it (when ready to reveal the information, remove the tape and let the page drop).

- Face the participants, not the flipchart, while talking.

TRANSPARENCIES

The overhead projector is one of the most commonly used and most versatile pieces of audiovisual equipment. This visual aid projects images onto a screen using transparency film and silhouettes of opaque objects. A transparency is a plastic or acetate sheet (film) containing written or drawn material; it should be created in landscape (horizontal) rather than portrait (vertical) format (see **Sample 4-1**). An overlay is one transparency placed over another to show complex information. For example, in a presentation on female anatomy, the trainer could use one transparency showing the uterus and a second transparency, which is laid over the first, showing the surrounding organs.

The **advantages** of using transparencies are:

- The projector is simple to use, can be used in almost any training room which has electricity and is less sensitive to fluctuations in voltage than film and slide projectors.

- The projector can be used with the classroom lights on, allowing participants to take notes.

- Use of transparencies that have been prepared in advance saves time (writing on a board is slower than talking) and allows the trainer more time for discussion with participants.

- They are inexpensive and can be prepared quickly and easily.

- They can be used repeatedly.

The primary **disadvantage** of transparencies is that the clinical trainer cannot project text and images directly from the printed page. Also, the clinical trainer must be careful not to block the participants' view of the screen.

Making Transparencies

There are three ways to produce transparencies:

- Use permanent or non-permanent (water soluble) pens to create text or drawings on plastic or acetate sheets.

- Use a copy machine with transparency film designed for copiers. Any original that produces a copy of acceptable quality on paper will produce an equivalent copy on transparency film. The transparencies are loaded in the appropriate copier paper tray and the transparency master is placed on the glass copier surface and copied onto the transparency film.

- Use a computer and printer. The information to appear on the transparency is produced on the computer using word processing or graphics software. The page is then printed on special transparency film.

Guidelines for Preparing Transparencies

Limit the information on each transparency to one main idea and about five to six lines of large type.

- Use large lettering (at least 5 mm tall, preferably larger if printing, or 18 point or larger if using a computer) as seen in **Sample 4-1**. Ordinary typed materials or a page from a book are not suitable for transparencies unless they are enlarged, which can be done on many photocopy machines.

- Print text. It is easier to read than script handwriting.

- Make graphics and drawings large enough to be seen easily in the back of the room.

- Mount transparencies in standard mounting frames or insert them in plastic pockets with frames. These provide a more professional finish, make the transparencies easier to handle and also protect them.

- Number the transparencies to keep them in the correct order (the number can be written on the transparency itself or on its outside frame).

- Store the transparencies in a box with a lid, in an envelope or a "pocket" made from manila folders or sheets of clear plastic to protect them from dust and scratches.

Tips for Using the Overhead Projector

- Before the presentation begins, locate and check the operation of the on/off switch.
- Be sure that there is an extra projector bulb and that it is working. Some overhead projectors have two bulbs so that if one burns out, a second is available at the flick of a switch.
- Focus the projector and check the position of the image on the screen using a transparency before beginning the session.
- Turn the projector on after the transparency is placed on the glass and turn it off before removing the transparency.
- Once the projector is on and the image is on the screen, move away from the projector to avoid blocking the participants' view of the screen.
- Face the participants, not the screen, while talking.
- Show one point at a time and control the pace of the discussion by covering selected information with a piece of paper. (The paper can be placed either on top of or beneath the transparency and moved down to reveal the next item.)
- Use a pointer or pencil directly on the transparency to focus attention on a specific area; this allows the trainer to maintain direct eye contact with the participants.
- Allow plenty of time for the participants to read what is on the screen and take notes, if necessary.

SLIDES

The 35 mm slide projector is a commonly used audiovisual aid which offers many of the same advantages as the overhead projector. Color slides of clinical procedures, infection prevention practices and clients can be prepared by the clinical trainer for use during training. Text or information slides for presentations can also be prepared using various types of computer software. These slides may be projected onto a screen using the computer and a special projection unit. Once generated on the

computer, an electronic file of the slides may also be sent to a developer who can create a set of 35 mm slides. Slide sets covering specific topics or procedures sometimes are provided as part of a learning package.

The **advantages** of using slides are that they:

- Are relatively inexpensive and easy to produce, and can be made locally by the trainer
- Are good for showing individual (detailed) steps of a clinical procedure or close-ups of equipment
- Can be shown in a fairly light room which allows the participants to take notes
- Can be used with audiotapes to produce a slide show with narration

The **disadvantages** of using slides are:

- Slide projectors are much more expensive than overhead projectors.
- Slide projectors are more fragile than and do not tolerate voltage fluctuations as well as overhead projectors.
- They are not updated as easily or produced as inexpensively as transparencies.

Guidelines for Preparing Slides

- Limit each slide to one main idea; detailed information should be put into a handout, not on a slide.
- Text slides should be short and concise. It is recommended that a slide contain no more than 35 words (approximately five lines of text).
- Legibility of the material on the slide is crucial. A good rule is that if a slide can be read by the naked eye—without a projector—it will be legible to participants in the back of the room when it is projected.

Number the slides in pencil or pen on the mounting frame.

- It is essential to mark or "spot" slides for projection:
    - Place the slide on a light box (an overhead projector is ideal) or hold it up to the light, so that the image appears as it will on the screen.

- Turn the slide upside down.
- With the slide upside down, mark or number the slide in the upper right-hand corner.
- When inserting the slide in the slide tray, place it upside down (the mark or number should be visible in the upper right-hand corner).

Tips for Using the Slide Projector

- Arrange the room so that all participants can see the screen; make sure that there is nothing between the projector and the screen.
- Set up and test the slide projector before the participants arrive.
- Make sure there is an extra projector bulb in working condition; practice replacing the bulb.
- Locate the focus control and check the focus of the projector and position of the image on the screen.
- Run through all the slides in advance to ensure that they are in the correct sequence and inserted properly in the slide tray (with the mark or number in the upper right-hand corner).
- Determine if all or some of the lights can be left on during the slide presentation; this will make note taking easier for the participants.
- During the presentation, avoid rushing through a series of slides. This can be very frustrating for the participants. Take time to view and discuss each slide. When appropriate, ask participants questions regarding what they are seeing on a slide.

VIDEOTAPES

Videotapes can be very creative audiovisual aids. Using a single camera and recorder system, audio and video signals are recorded on videotape which can be played back on a videocassette machine and television screen or monitor.

The **advantages** of using videotapes are:

- Videotapes capture events the eye alone would not see. For example, a video camera attached to a laparoscope can project onto a television screen the details of tubal occlusion or gall bladder surgery.

- Individual steps of a clinical procedure or technique can be shown by slowing down the videotape or stopping (pausing) to analyze a single frame. Use of these techniques allows participants to watch and emulate a step-by-step demonstration of a technique, such as Norplant implants insertion, at their own pace.

- Videotapes provide better color and detail than traditional film.

- Videotapes can be prepared by the clinical trainer and/or participants to reflect local conditions.

- Commercially developed videotapes can be purchased or borrowed.

- Animation can be used to show an abstract concept, such as how various body organs function, in a concrete way; however, creating animated sequences requires special editing equipment.

- TV monitors, especially commercial grade, tolerate fluctuations in voltage much better than either overhead projectors or slide projectors.

- Video players are less expensive and easier to maintain than slide projectors.

There are some **disadvantages** to using videotapes in clinical training:

- Commercially prepared videotapes are often outdated and may show techniques or equipment that are inconsistent with currently approved medical practice.

- Videotapes may have been edited and therefore omit or rearrange key training steps in the procedure.

- Participants may be distracted by cultural differences such as accents, appearance or communication customs.

If it is absolutely necessary to use outdated videos, it is crucial that the clinical trainer point out the differences or inconsistencies before the video is shown. If there are considerable differences, omit the videotape entirely and substitute demonstrations with anatomic models or slides.

Tips for Using Videotapes

- Preview the videotape to ensure that it is appropriate for the participants and consistent with the course objectives.

- Before the training session, check to be sure that the videotape is compatible with the videotape player. Run a few seconds of the tape to ensure that everything is functioning properly.
- Cue the videotape to the beginning of the program.
- Arrange the room so that all participants can see the video monitor.
- Prepare the participants to view the videotape:
    - State the session objective.
    - Provide an overview of the videotape.
    - Focus participants' attention by asking that they look for a number of specific points during the viewing of the videotape.
- Discuss the videotape after it has been shown. Review the main points that the participants were asked to watch for as they viewed the videotape.
- Prepare test items based on the videotape content if appropriate.

SUMMARY

Audiovisual aids play an important role in the clinical training process. They offer the trainer a variety of ways to present information, and can be used to highlight important points or key steps for the participants. The most important audiovisuals that the clinical trainer must learn to use effectively are writing boards, flipcharts, overhead transparencies, slides and videotapes.

TEXT OF A TRANSPARENCY FROM AN IUD TRAINING COURSE

Objective

After completion of this session, you will be able to counsel family planning clients requesting IUD services. Competency will be measured by scoring at least 85% on the midcourse questionnaire and by demonstrating appropriate counseling skills during classroom role plays and when working with clients.

FIVE

DELIVERING INTERACTIVE PRESENTATIONS

INTRODUCTION

An effective presentation can be one of the most rewarding aspects of a clinical trainer's responsibilities. The clinical trainer able to maintain participant interest with an exciting, dynamic delivery using a variety of learning techniques is more likely to be successful in helping participants reach course objectives. The clinical trainer will find that the time and effort invested in precourse planning were well spent as the clinical trainer and participants interact, discuss, question and work together.

As described in **Chapter 3**, there are a number of presentation skills that the trainer can use to make a training session more effective. This chapter focuses on delivering interactive presentations—lectures, case studies, role plays, brainstorming and discussions—using a variety of approaches.

Chapter Objective

After completing this chapter, the participant will be able to plan and deliver interactive presentations when introducing new knowledge and clinical skills.

Enabling Objectives

To attain the chapter objective, the participant will:

- Present an illustrated lecture
- Facilitate a small group activity
- Facilitate the use of a case study
- Facilitate the use of a role play
- Conduct a brainstorming session
- Facilitate a discussion

PLANNING AND PRESENTING AN ILLUSTRATED LECTURE

The most common type of traditional classroom presentation is the illustrated lecture, in which the content is derived largely from the knowledge area and presented orally by the clinical trainer. Its effectiveness as a training method is markedly enhanced through the use of questioning techniques and well-designed audiovisuals such as transparencies, flipcharts and videotapes. (See **Chapter 4** for detailed information on using audiovisuals.)

Advantages and Disadvantages

The illustrated lecture offers a number of **advantages**:

- When properly designed and presented, it is effective for mixed groups of experienced and new learners.
- An illustrated lecture can be used to deliver large amounts of information in a relatively short period of time.
- The audience for an illustrated lecture can be a larger group than is feasible for brainstorming, discussions and other small group activities.
- The clinical trainer controls the content and delivery (what is said and when it is said).

There are, however, several **disadvantages** to the illustrated lecture:

- Lecturing is a demanding activity! The clinical trainer and participants must be able to sustain concentration and attention, sometimes for extended periods of time.
- Participants' involvement and contributions may be minimal if the clinical trainer fails to encourage participant interaction.
- The lecture usually proceeds at a pace dictated by the clinical trainer. Participants' understanding of the information should be monitored through questioning and feedback to assure that the presentation is not moving too rapidly or, equally important, too slowly.
- There is a tendency to overload participants with **too much information**. Presentation of too much information strains short-term memory capacity.

Planning an Illustrated Lecture

Situation 1: You and a cotrainer are conducting a clinical skills training course. Your cotrainer is delivering an illustrated lecture during the first session of the course. As you observe, you note that your cotrainer is experiencing difficulty in maintaining eye contact with the participants while at the same time glancing at the notes he has made in his reference manual. He is looking at the reference manual so often that his eye contact with the participants is minimal. What suggestions for correcting this problem would you offer your cotrainer?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

The **first step** in planning an illustrated lecture is to review the lecture objectives. Will the illustrated lecture be the most appropriate strategy to meet the objectives? The clinical trainer's plan for giving an illustrated lecture should contain:

- The lecture objective(s)
- An outline of key points highlighted in the reference manual, written on paper or put on transparencies or flipchart pages
- Questions to involve the participants
- Reminders of participant activities, use of audiovisual aids, etc.

The purpose of the **outline** is to allow the clinical trainer to glance at the key points without reading the content to the participants. Questions to be asked should be noted at appropriate places in the outline. Notes regarding the use of audiovisuals or class activities also should be made at those points in the presentation where they are to be used.

An effective illustrated lecture:

- Begins with a **strong introduction**
- Is followed by a **smooth transition** into the body of the lecture
- Follows the **planned outline**
- Uses a variety of **audiovisual aids**
- Includes activities that **involve the participants**
- Concludes with an **effective summary**

Delivering an Illustrated Lecture

Situation 2: A colleague is preparing to give a presentation to a group of nursing students. She appears to be a little nervous about the presentation and explains that she plans to have a lectern in the front of the room so that she can stand there and look at her notes. She asks you what you think about using the lectern. What is your response?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

When information is presented using an illustrated lecture, how the content is delivered is as important as what is being said. The presentation may include very important information, but if the trainer speaks in a

monotone, lacks excitement, fails to maintain eye contact and stands behind a table, the participants will lose interest and fall asleep. By

contrast, the trainer using an energetic delivery style is more likely to maintain interest.

Using the presentation skills described in **Chapter 3** will distinguish the effective clinical trainer from the traditional lecturer. This interactive approach will keep adult learners interested and involved in learning. Remember to:

- Follow a plan and use trainer's notes.
- Communicate on a personal level.
- Maintain eye contact with participants.
- Project your voice.
- Avoid the use of slang or repetitive words, phrases or gestures.
- Display enthusiasm about the topic and its importance.
- Move about the room.
- Use appropriate audiovisual aids.
- Ask both easy and more challenging questions.
- Provide positive feedback.
- Use participants' names.
- Display a positive use of humor.
- Provide smooth transitions between topics.
- Be an effective role model.

FACILITATING SMALL GROUP ACTIVITIES

Situation 3: During a clinical skills course the trainer divides the participants into small groups to brainstorm the possible results of poor infection prevention practices. After about 15 minutes, the trainer asks one of the groups to report its results. The group reporter shares all of the group's items. When the trainer goes to the remaining groups, their reporters indicate they have nothing else to add to the first group's items. The trainer then moves on the next learning activity. What did this trainer do well? How could this activity have been improved?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

There are many times during training when the participants will be divided into several small groups, usually consisting of four to six participants. Examples of small group activities are:

- **Solving a problem** that has been presented by the clinical trainer or another participant
- **Reacting to a case study** that can be presented in writing, orally by the clinical trainer or through videotape or slides
- **Preparing a role play** within the small group and presenting it to the group as a whole

Small group activities offer many advantages including:

- Providing participants an opportunity to **learn from one another**
- **Involving** all participants
- Creating a sense of **teamwork** among members as they get to know one another
- Providing for a **variety of viewpoints**

When small group activities are being conducted, it is important that participants not be in the same group every time. The clinical trainer can create small groups by:

- **Assigning** participants to groups
- Asking participants to **count off** "1, 2, 3," etc. and having all the "1s" meet together, all the "2s" meet together, etc.
- Asking participants to **form their own groups**
- Asking participants to **draw a group number** (or group name) from a basket

The classroom(s) used for small group activities should be large enough to allow several arrangements of tables and chairs so that individual groups can work without disturbing one another. The clinical trainer should be able to move easily about the room to visit each group. If available, consider using smaller rooms (known as breakout rooms) near the primary classroom where small groups can go to work on their problem-solving activities, case studies or role plays.

Activities assigned to small groups should be **challenging, interesting and relevant; should require only a short time to complete; and should be appropriate for the background of the participants**. Each small group may be working on the same activity or each group may be taking on a different problem, case study or role play. Regardless of the type of activity, there is usually a time limit. When that is the case, inform groups when there are 5 minutes left and again when their time is up.

Instructions to the groups may be presented:

- In a **handout**
- On a **flipchart**
- On a **transparency**
- **Orally** by the clinical trainer

Instructions for small group activities typically include:

- **Directions**
- **Time** limit
- A **situation or problem** to discuss, resolve or role play
- Participant **roles** (if a role play)
- **Questions** for a group discussion

After the groups have completed their activity, the clinical trainer will bring them together as a large group for a discussion of the activity. This discussion may involve:

- **Reports** from each group
- **Responses** to activity questions
- **Role plays** developed and presented by participants in the small groups
- **Recommendations** from each group

It is important that the clinical trainer provide an effective summary discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

FACILITATING CASE STUDIES

Situation 4: You are attending a clinical training skills course in order to learn to be an effective clinical trainer. During the course you will be expected to make several presentations. You have been asked to make a presentation that will include a case study. You have created a case study but are unsure what you will have the participants do after they have worked on the case study in small groups. What are your options?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

A case study is a training method using realistic scenarios that focus on a specific issue, topic or problem. It is used principally to reinforce or expand the participants' **knowledge**. Participants typically read, study and react to the case study orally during a group discussion or in writing. The primary **advantage** of the case study is that it focuses the attention of the participant on a **real situation**. Participants may work separately or in small groups to solve or complete a case study.

Advantages of using a case study are listed below.

- It is a **participatory** method of learning which actively involves participants and encourages them to interact with one another.
- Participants react to **realistic and relevant cases** which relate directly to the course and often to their work environment.
- Reactions often provide **different perspectives** and **different solutions** to problems presented in the case study.
- Reacting to a case study helps participants **develop problem-solving skills**.

Case studies can be developed by the clinical trainer or the participants. Situations for the case studies can be found in one or more of the following sources:

- Clinical experiences the trainer has had
- Medical histories/records, reference manuals, clinical journals, etc.
- Experiences from clinic staff, participants or clients

After participants have read the case study, either individually or in small groups, they should be given the opportunity to react to it. Typical reaction exercises include:

- **Analysis of the problem.** The participants are asked to analyze the situation presented in the case study and determine the source of the problem.

- **Focused questions.** These inquiries ask participants to respond to specific questions.

  Example:

  "What are three observations suggesting that the client was not counseled properly?"

- **Open-ended questions.** These questions provide participants more flexibility in responding.

  Example:

  "What are some of the consequences of failing to counsel a client properly prior to performing a minilaparotomy?"

- **Problem solutions.** The participants are asked to offer suggestions regarding the situation being presented.

  Example:

  "How could this problem have been avoided?"

Once participants have reacted to the case study they should be given the opportunity to share their reactions. This sharing might take the form of one or more of the following:

- **Reports** from individuals or small groups
- **Responses** to case study questions
- **Role plays** presented by individuals or small groups
- **Recommendations** from individuals or small groups

The clinical trainer should summarize the results of the case study activity before moving on to the next topic.

An example of a case study is presented in **Sample 5-1** at the end of this chapter.

FACILITATING ROLE PLAYS

> **Situation 5**: You are working in a small group during a clinical skills course. The objective of the activity is to create a counseling role play which your group will present to the entire group. One of the participants appears to be very nervous about getting up in front of the large group. You are concerned that if this participant is "forced" to get up in front of everyone, she will have a very negative experience. What should you do?
>
> Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

A role play is a learning method in which participants act out roles in a situation related to the learning objectives. Although knowledge is usually required to conduct an effective role play, its purpose is to influence the **behavior** of participants. Role play has several advantages:

- Role play can create a highly motivational climate because participants are actively involved in a realistic situation.
- Participants can **experience a real-life situation without having to take real-life risks**.
- Role play gives participants an understanding of the client's situation.

  Examples:

  - Make participants aware of the communication skills needed to counsel a client about family planning by asking them to assume the roles of the client seeking contraception and a family planning counselor.
  - Practice a clinical skill by asking two participants to role play the procedure using an anatomic model (e.g., insert an IUD using the pelvic model).
  - Reinforce a session on coaching skills by asking participants to prepare and present a role play demonstrating the coaching process during a minilaparotomy.

To conduct the role play, the clinical trainer should:

- Decide what the participants should learn from the role play (the objectives)
- Devise a simple situation
- Explain what the participants should do and what the audience should observe
- Discuss important features of the role play by asking questions of both the players and observers
- Summarize what happened in the session, what was learned and how it applies to the clinical skill or activity being learned

An example of a role play can be found in **Sample 5-2** at the end of this chapter.

FACILITATING BRAINSTORMING SESSIONS

Situation 6: During a clinical skills course your cotrainer decides to conduct a brainstorming session. He announces the topic and then looks to the group for responses. One of the participants raises her hand and offers a suggestion. The trainer takes a minute to describe why that response is not appropriate. After that exchange, very few other participants offer suggestions. What advice would you give your cotrainer?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Brainstorming is a training strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that participants have some background information related to the topic.

The following guidelines will facilitate the use of brainstorming:

- **Establish ground rules.**

Example:

"During this brainstorming session, we will be following two basic rules. All ideas will be accepted; Alain will write them on the flipchart. At no time will we discuss or criticize any idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not,...."

- **Announce the topic or problem.**

  Example:

  "During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is 'Indications for Use of Norplant Implants.' I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Ilka...."

- **Maintain a written record** on a flipchart or writing board of the ideas and suggestions. This will prevent repetition and keep participants focused on the topic, and will be useful when it is time to discuss each item.

- **Involve the participants and provide positive feedback** in order to encourage more input.

- **Review written ideas** and **suggestions periodically** to stimulate additional ideas.

- **Conclude brainstorming by reviewing all the suggestions.**

FACILITATING GROUP DISCUSSIONS

Situation 7: You are conducting a clinical skills course and are facilitating a discussion focusing on problems encountered during counseling. One of the participants offers an opinion and another participant takes a different view. For a few minutes there is a lively discussion between these two participants. Suddenly you realize that one of the participants is getting upset and that you need to assume control of the discussion. How do you do this?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

The group discussion is a training technique in which most of the ideas, thoughts, questions and answers are developed by the participants. The clinical trainer typically serves as the **facilitator** and guides participants as the discussion develops.

Group discussion is useful:

- At the conclusion of a training session
- After viewing a videotape
- Following a clinical demonstration
- After reviewing a case study
- After a role play
- Following a brainstorming session
- At any other time when participants have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when participants have limited knowledge of or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When participants are familiar with the topic, the ensuing discussion is likely to **arouse participant interest**, **stimulate thinking** and **encourage active participation**. This interaction affords the facilitator an opportunity to:

- Provide positive feedback
- Emphasize key points
- Create a positive learning climate

The facilitator must consider a number of factors when selecting group discussion as the training strategy:

- Discussions involving **more than 15 to 20 participants** may be difficult to lead and may not give all participants an opportunity to participate.

- Discussion requires **more time** than an illustrated lecture because of extensive interaction among the participants.

- **A poorly directed discussion may move away from the subject** and never reach the objectives established by the facilitator.

- **If control is not maintained**, a few participants may dominate the discussion while others lose interest.

In addition to **group discussion** that focuses on the session objectives, there are two other types of discussions that may be used in a training situation:

- **General discussion** that addresses participant questions about a training topic (e.g., why one technique of tubal occlusion is preferred over another in minilaparotomy)

- **Panel discussion** in which a moderator conducts a question and answer session among panel members and participants

Follow these key points to ensure successful group discussions:

- **Arrange seating to encourage participant interaction** (e.g., tables and chairs set up in a "U" shape, square or circle so that participants face one another).

- **State the topic** as part of the introduction.

  Example:

  "To conclude this presentation on management styles, let's take a few minutes to discuss the importance of human relations and the supervision of nursing staff. Youssef, what do you think about the role of human relations and supervision?"

- **Shift the conversation** from the facilitator to the participants.

  Examples:

  "Abdul, would you share your thoughts on...?"
  "Rosa, what is your opinion?"
  "Michelle, do you agree with my statement that...?"

- **Act as a referee** and intercede only when necessary.

  Example:

"It is obvious that Alain and Ilka are taking opposite sides in this discussion. Alain, let me see if I can clarify your position. You seem to feel that...."

- **Summarize the key points** of the discussion periodically.

  Example:

  "Let's stop here for a minute and summarize the main points of our discussion."

- **Ensure that the discussion stays on the topic.**

  Examples:

  "Sandra, can you explain a little more clearly how that situation relates to our topic?"

  "Monica, would you clarify for us how your point relates to the topic?"

  "Let's stop for a moment and review the purpose of our discussion."

- **Use the contributions of each participant** and provide positive reinforcement.

  Examples:

  "That is an excellent point, Rosminah. Thank you for sharing that with the group."

  "Alex has a good argument against the policy. Biran, would you like to take the opposite position?"

- **Minimize arguments** among participants.

- **Encourage all participants to get involved.**

  Example:

  "Maria, I can see that you have been thinking about these comments. Can you give us your thoughts?"

- **Ensure that no one participant dominates the discussion.**

Example:

"Christina, you have contributed a great deal to our discussion. Let's see if someone else would like to offer...."

- **Conclude the discussion with a summary** of the main ideas. The facilitator must relate the summary to the objective presented during the introduction.

SUMMARY

The learning techniques described in this chapter are both non-traditional, such as small group activities, case studies, role plays, brainstorming and group discussions, and traditional, such as illustrated classroom lectures. The clinical trainer who wants to deliver an interactive presentation should use a variety of these techniques to involve participants in the learning process. Delivering an effective presentation can be one of the most satisfying aspects of a clinical trainer's responsibilities. The clinical trainer who can use these learning methods effectively to give an exciting, dynamic presentation that holds the participants' interest is more likely to be successful in helping participants reach the course objectives.

SITUATION RESPONSES

Situation 1 That the cotrainer has made notes in the manual is a positive sign that he is preparing for his presentations. That he is looking at his manual too much, however, is a sign that his notes are difficult to read, there are too many notes or he is not very familiar with the content. Assuming the problem lies with the notes, you might suggest that he put his major notes or points on the flipchart or on an overhead transparency. This will allow him to glance at the flipchart or screen and still maintain eye contact with the participants.

Situation 2 Explain that using a lectern can limit a trainer's movement and that those who stand behind the lectern tend to read their notes and limit their interaction with the participants. Moving around the room keeps the participants more focused and encourages the presenter to maintain eye contact and interact. If the lectern is already there, try to glance at your notes (or put them on an overhead transparency or flipchart) and then leave the lectern and move around the room.

Situation 3 Dividing the participants into small groups to work on the brainstorming exercise was a good approach. The reporting out by the groups would have been better handled if each group had been asked to share just one item. This ensures that each group has an opportunity to share the results of their work. After several times around the groups, all of the items will have been identified.

Situation 4 Depending on the time available, you could have the participants analyze the problem and answer focused or open-ended questions, and/or present the solution to the case study. The participants might also act out the case study during a brief role play.

Situation 5 If at all possible, share your concern privately with the trainer. Since this is a clinical skills course and these are service providers, doing a presentation to a large group is not a realistic job expectation. Allowing the participant to take a less active role will prevent her from being embarrassed and will help make the role play a success.

Situation 6 One of the basic rules of brainstorming is not to discuss any of the items being offered by the participants. This can take the momentum out of the session, especially when there is negative feedback and other participants may not want to risk being wrong. The trainer should conclude the brainstorming session before discussing any of the items.

Situation 7 Allowing two of the participants to debate an issue is a healthy part of a discussion. After a few minutes or if tempers begin to flare, however, the trainer needs to assume control of the discussion. In this situation, the trainer might try saying, "Mary and Robert both seem to have strong opinions on this topic. Jane, what do you think?" This shift to another participant will give the two participants who disagree a chance to settle down as others enter into the discussion.

SAMPLE 5-1

CASE STUDY FOR SERVICE PROVIDER TRAINING COURSE IN IUD SKILLS

Directions for Participants

Divide into small groups. Read and study this case study individually. As a group, agree on the answers to the questions. When all of the groups have finished their discussion, the case study and answers from all of the groups will be reviewed in a group discussion.

Case Study

> *A 20-year-old recently divorced woman with no children comes to the clinic requesting an IUD. She is not currently sexually active but has recently started to see a man and thinks it may develop into a long-term relationship. She says that many of her friends are using IUDs and that they are very satisfied.*

Question: After exchanging greetings with this client, how should the service provider proceed? What kind of counseling issues need to be discussed?

Notes for the clinical trainer: There are several issues which can be raised using this case study:

1. How should counseling best proceed when a client requests a specific method? Should the counselor review all the methods or should the counselor focus on discussing those methods which might be most appropriate given the client's lifestyle and needs? Finally, should the provider focus on ensuring that the client's request is appropriate for her and ensure that in choosing that method, the client has made an informed choice? (Resource: IUD reference manual, Chapter 2, pp. 2-2 to 2-4)

2. Does this client have any risk factors for potential health problems with IUD use? (Resource: IUD reference manual, Chapter 3, p. 3-3)

3. Does the nature of the relationship with her partner (or proposed partner) play any part in determining whether the IUD is appropriate for this woman? (Resource: IUD reference manual, Chapter 3, p. 3-5)

SAMPLE 5-2

ROLE PLAY FOR SERVICE PROVIDER TRAINING COURSE IN MINILAPAROTOMY SKILLS

Directions for Participants

Two participants in your group will volunteer for (or will be assigned) roles. One will be a clinician, the other a client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play.

Participant Roles

Clinician: The physician is very experienced and has performed a number of minilaparotomies under local anesthesia. The physician is visiting a clinic for the first time to perform surgery and has not worked with the clinic staff before.

Client: The client is a 37-year-old woman with six children. She has never been examined by a physician, is very nervous, and has received limited counseling. She has consented to a minilaparotomy under local anesthesia. When the physician enters the examination room it becomes evident that the client is very nervous and frightened.

Focus of the Role Play: The focus of the role play is on the interaction between the physician and client. The physician must counsel and reassure the client. The client should continue to be nervous until the physician chooses the appropriate words and expressions that will inform and calm the client.

Discussion Questions

1. Did the physician approach the client in a positive, reassuring manner?

2. Did the physician's approach have the planned effect on the client? What other approaches would have been effective?

3. Were the client's fears realistic?

4. How could this problem have been avoided?

SIX

USING COMPETENCY-BASED ASSESSMENT INSTRUMENTS

INTRODUCTION

Providing participants with good counseling and clinical skills is one of the central purposes of most family planning training courses. Being able to **measure learning progress satisfactorily** and **evaluate performance objectively** are extremely important elements in the process of improving the quality of clinical training.

It is the responsibility of the clinical trainer to determine whether each participant has acquired the knowledge, attitudinal concepts and skills defined in the training course objectives. This is accomplished through the use of knowledge and skill assessments. When these assessments are based on the **mastery learning** approach to clinical training (described in **Chapter 1**), learning is measured through the following means:

- Initial assessment of each participant's and the group's general knowledge and skills in the course content. Such preliminary assessments guide the clinical trainer and participants in their work together during the course.

- Continual assessment of each participant's mastery of the knowledge and skills defined in the course objectives.

With this approach, "testing" is used to ensure competency in providing the clinical skill or activity rather than just to assess an increase in knowledge (i.e., differences between pre- and post-test scores).

Chapter Objective

After completing this chapter, the participant will be able to use competency-based knowledge and skill assessment instruments to measure progress in learning and evaluate performance.

Enabling Objectives

To attain the chapter objective, the participant will:

- Explain how competency-based knowledge assessments are used in clinical training

- Explain how competency-based skill assessments are used in clinical training

KNOWLEDGE ASSESSMENTS

Assessment of knowledge (testing) is an important factor in determining the success of training. Knowledge assessment is conducted to:

- Determine participant knowledge of the subject at the beginning of the course (**precourse questionnaire**)
- Motivate the participant to acquire new knowledge
- Determine whether progress has been made toward achieving the training objectives (**midcourse questionnaire**)

Writing **valid** and **reliable** questions requires special skills and considerable practice and experience. Therefore, to improve the quality of knowledge assessment, clinical trainers increasingly are provided with pretested questionnaires, often as part of a learning package.

Precourse Questionnaire

The main objective of a precourse questionnaire in the mastery learning approach is to assess what the participants, individually and as a group, know about the course content. It allows the clinical trainer to identify topics that may need additional emphasis or, in some cases, require less classroom time during the course. Providing the results of the precourse assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course. Because only general information is being tested in a precourse questionnaire, questions should be presented in the **true-false** format, which is simple to complete and easy to score. (**Sample 6-1** is a section of the true-false questions from the Precourse Questionnaire from a Norplant implants clinical skills course.)

A form, the **Individual and Group Assessment Matrix** (**Sample 6-2**), can be used to record the scores of all course participants. Using this form, the clinical trainer and participants can quickly chart the number of correct answers for each of the questions. By examining the data in the matrix, the group can easily determine their collective strengths and weaknesses and jointly plan with the clinical trainer how best to use the course time to achieve the desired learning objectives.

For the clinical trainer, the participants' answers to this questionnaire will help identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 80% or more of the participants answer the questions correctly, the clinical

trainer may elect to use some of the allotted time for other purposes. In an IUD course, for example, if the participants as a group did well (80%

or more correct) in answering the questions in the category "Indications, Precautions and Client Assessment," the clinical trainer might assign the relevant chapters of the reference manual as homework rather than discuss these topics in detail during class.

For the participants, the learning objective(s) related to each question and the corresponding chapter(s) in the reference manual should be noted beside the answer column. To make the best use of the limited course time, participants may address their own individual learning needs by studying the designated chapter(s).

Midcourse Questionnaire

The main purpose of a midcourse questionnaire, which is administered as soon as all scheduled subject areas have been covered, is to help each participant and the clinical trainer assess the participants' progress in mastering the course objectives. **Multiple-choice** test items are used in this situation rather than **true-false** because they are a better measure of knowledge assessment, reduce the chance of guessing the correct answer and can cover a broader range of content areas. (**Sample 6-3** is a section of multiple-choice questions from the Midcourse Questionnaire for a Norplant implants course.)

It is suggested that a correct score of 85% or more indicates knowledge-based mastery of the material presented in the course. For participants scoring less than 85% on their first attempt, the clinical trainer should review the results with each participant individually and provide guidance on using the course materials (e.g., reference manual) to learn the required information. Participants scoring less than 85% must retake the midcourse questionnaire until they achieve that score or better. They may do so at any time during the remainder of the course.

SKILL ASSESSMENTS

In the past, deciding whether a participant was competent (qualified) to perform a skill or activity during and, most important, after clinical training was often extremely difficult. This was due, in part, to the fact that competency was tied to the completion of a specified number of supervised procedures or activities. Unfortunately, unless participant performance is objectively measured relative to a predetermined standard, it is difficult to determine competency.

Competency-based skill assessments (learning guides and checklists), which measure clinical skills or other observable behaviors relative to a predetermined standard, have made this task much easier. While **learning guides** are used to **facilitate learning** the steps or tasks (and sequence, if necessary) in performing a particular skill or activity, **checklists** are used to **evaluate performance** of the skill or activity objectively.

Learning guides and checklists can be developed for any clinical skill or activity (e.g., counseling, IUD insertion). If the clinical trainer is working with a learning package, these assessments, together with instructions for their use, usually are included.

Terms Associated with Skill Assessments

Use of competency-based skill assessment instruments involves two terms that may be new to the clinical trainer. They are:

- **Psychomotor domain.** The domain or area of learning that often involves performing skills which typically require the manipulation of instruments and equipment (e.g., inserting an IUD).

- **Competency-based skill assessment.** An instrument used to objectively measure clinical (psychomotor) skills or other observable behaviors (e.g., counseling).

Psychomotor Skills (Levels of Performance)

The psychomotor or skill area involves tasks such as:

- Counseling a client
- Inserting Norplant implants
- Sterilizing instruments
- Inserting a Copper T 380A IUD
- Putting on sterile gloves

Progress in the skill area is measured with reference to various levels or stages of performance. The three levels of performance in acquiring a new skill, which are briefly described in **Chapter 1** (and are used throughout this manual), are defined more fully as follows:

- **Skill acquisition** represents the **initial phase** in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and the sequence (if necessary) in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

- **Skill competency** represents an **intermediate phase** in learning a new clinical skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.

- **Skill proficiency** represents the **final phase** in learning a new clinical skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary).

Advantages and Limitations

The single greatest advantage of a competency-based assessment is that it can be used to facilitate learning a wide variety of skills or activities and measure participant behaviors in a **realistic job-related situation**. Competency-based assessment instruments such as learning guides:

- focus on a skill that the participant typically would be expected to perform on the job, and

- break down the skill or activity into the essential steps required to complete the procedure.

When planning the use of competency-based assessments, the trainer must consider that:

- It will take time and energy first to develop the assessments, and then to apply them to each participant.

- An assessment can be applied only by a clinical trainer who is proficient in the clinical procedure or activity being learned.

- An adequate number of skilled clinical trainers must be available to conduct the training, because competency-based clinical training usually requires a one-on-one relationship (see **Chapters 1 and 7**).

Using Learning Guides

A learning guide contains the individual steps or tasks in sequence (if necessary) required to perform a skill or activity in a standardized way. Learning guides are designed to help the participant learn the correct steps and sequence in which they should be performed (**skill acquisition**), and measure progressive learning in small steps as the participant gains confidence and skill (**skill competency**).

The samples at the end of this chapter are taken from a learning package designed to train service providers in IUD counseling and clinical skills. They are:

Sample 6-4. Instructions for Using the Learning Guides and Practice Checklist for IUD Counseling and Clinical Skills

Sample 6-5. Learning Guide for IUD Counseling Skills

Sample 6-6. Learning Guide for IUD Clinical Skills

Using learning guides in competency-based clinical training:

- Ensures that training is based on a standardized procedure
- Standardizes training materials and audiovisual aids
- Forms the basis of classroom or clinical demonstrations as well as participant practice sessions

In addition, learning guides can be used as a self- or peer-assessment tool.

Examples of how learning guides can be used at different stages of the course are given below.

- Initially, participants can use the learning guides to follow the steps as the clinical trainer role plays counseling a client or demonstrates a clinical procedure using anatomic models.

- Subsequently, during the classroom sessions in which participants are paired, one "service provider" participant performs the procedure while the other participant uses the learning guide to prompt the "service provider" on each step. During these sessions, the clinical trainer(s) can circulate from group to group to monitor how learning is progressing and check to see that the participants are following the steps outlined in the learning guide.

- After participants become confident in performing the skill or activity (e.g., inserting an IUD in the pelvic model), they can use the learning guide to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference before participants provide services to clients.

- Before the first clinic session, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the learning guide to remind the "service provider" of any missed steps. During this session, the clinical trainer circulates, coaching the participants as necessary as they perform the procedure.

Using Checklists

The checklist generally is derived from a learning guide. Unlike learning guides, which are by necessity quite detailed, competency-based checklists focus only on the key steps or tasks. Well-constructed checklists should contain only sufficient detail to permit the clinical trainer to evaluate and record the overall performance of the skill or activity. If a checklist is too detailed, it can distract the clinical trainer from the primary purpose, which is to observe the overall performance of the participant objectively.

Using checklists in competency-based clinical training:

- Ensures that participants have mastered the clinical skills and activities, first with models and then with clients

- Ensures that all participants will have their skills measured according to the same standard

- Forms the basis for followup observations and evaluations

Sample 6-7 contains the **Instructions for Using the Checklist for IUD Counseling and Clinical Skills**. Reviewing these instructions will provide additional insight into the use of competency-based performance checklists.

The **Checklist for IUD Counseling and Clinical Skills** is given in **Sample 6-8**. When comparing it to the corresponding clinical portion of the learning guides (**Samples 6-5** and **6-6**), note that the checklist is shorter and focuses only on the key steps in the whole process.

The checklist is first used to assess participants' performance on models. After participants demonstrate competency, they can work with clients, and the checklist is once again used to assess their performance.

When completed, this checklist, together with the clinical trainer's comments and recommendations, provides objective documentation of the participant's level of performance. Furthermore, it serves as one part of the process of attesting that the participant is qualified to provide the clinical service (e.g., IUD insertion) or activity (e.g., counseling). (See section on "Qualification" in **Chapter 9** for additional information.)

SUMMARY

Providing participants with good counseling and clinical skills is one of the central purposes of most family planning courses. The use of well-

designed, competency-based knowledge and skill assessment instruments can make mastering these skills easier.

The knowledge questionnaires described in this chapter are used to guide the clinical trainer in conducting the course. In contrast to pre- and post-tests, which are one-time assessments of an increase in knowledge, the questionnaires described here measure progress in learning. Learning guides enable participants to chart their progress in learning new skills and, by breaking the skill or activity down into its essential elements, to pinpoint areas for improvement.

Finally, evaluating whether participants have acquired new skills can be accomplished using competency-based (performance) checklists. These checklists can be used to measure a wide variety of participant skills and behaviors in realistic job-related situations.

SAMPLE 6-1

PRECOURSE QUESTIONNAIRE FROM A NORPLANT IMPLANTS COURSE

Instructions: In the space provided, print a capital **T** if the statement is **true** or a capital **F** if the statement is **false**.

COUNSELING

1.	The physician is the person best qualified to choose a contraceptive method for a woman in good health.	_____	Participant Objective 1 (Chapter 2)
2.	Counseling should be integrated into each interaction with the client.	_____	Participant Objective 1 (Chapter 2)
3.	Knowing that Norplant implants have few side effects may help a woman feel more confident about choosing Norplant implants as her contraceptive method.	_____	Participant Objective 1 (Chapter 2)
4.	If inserted within the first 7 days of menses, Norplant implants become effective in preventing pregnancy within 24 hours.	_____	Participant Objectives 1 and 7 (Chapters 1 and 6)

NORPLANT IMPLANTS TRAINING COURSE: INDIVIDUAL AND GROUP ASSESSMENT MATRIX

COURSE:_____ **DATES:**_____ **CLINICAL TRAINER(S):**_____

Question Number	CORRECT ANSWERS (Participants)																						CATEGORIES
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	18	19	20	21	22	23	24	
1																							COUNSELING
2																							
3																							
4																							
5																							INDICATIONS, PRECAUTIONS AND CLIENT ASSESSMENT
6																							
7																							
8																							
9																							INFECTION PREVENTION
10																							
11																							
12																							METHOD PROVISION (INSERTION AND REMOVAL)
13																							
14																							
15																							
16																							FOLLOWUP, SIDE EFFECTS AND OTHER PROBLEMS
17																							
18																							
19																							
20																							

SAMPLE 6-3

MIDCOURSE QUESTIONNAIRE FROM A NORPLANT IMPLANTS COURSE

USING THE QUESTIONNAIRE

This knowledge assessment is designed to help the participants monitor their progress during the course. By the end of the course, **all** participants are expected to achieve a score of 85% or better.

The questionnaire should be given at the time in the course when all subject areas have been presented. A score of 85% or more correct indicates knowledge-based mastery of the material presented in the reference manual. For those scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual to learn the required information. Participants scoring less than 85% can retake the questionnaire at any time during the remainder of the course.

Repeat testing should be done only after the participant has had sufficient time to study the reference manual.

Instructions: Write the letter of the single **best** answer to each question in the blank next to the corresponding number on the attached answer sheet.

1. For a woman in good health, a contraceptive method is best selected by the:

    a. woman herself
    b. physician providing health services to the woman
    c. counselor who sees the woman
    d. woman's husband

2. The most important part of counseling is:

    a. providing brochures about contraceptive methods to the woman for review with her partner
    b. identifying the woman's concerns about using contraceptives and answering her questions
    c. obtaining formal consent for the procedure from the client
    d. describing adverse side effects to the client

ANSWER KEY

1. For a woman in good health, a contraceptive method is best selected by the:

    A. WOMAN HERSELF
    b. physician providing health services to the woman
    c. counselor who sees the woman
    d. woman's husband

2. The most important part of counseling is:

    a. providing brochures about contraceptive methods to the woman for review with her partner
    B. IDENTIFYING THE WOMAN'S CONCERNS ABOUT USING CONTRACEPTIVES AND ANSWERING HER QUESTIONS
    c. obtaining formal consent for the procedure from the client
    d. describing adverse side effects to the client

SAMPLE 6-4

INSTRUCTIONS FOR USING THE LEARNING GUIDES AND PRACTICE CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS

The Learning Guides and Practice Checklist for IUD Counseling and Clinical Skills are designed to help the participant learn the steps or tasks involved in:

- Counseling a potential family planning client
- Counseling a client requesting IUD insertion or removal
- Inserting and removing the Copper T 380A IUD

There are two **learning guides** in this handbook:

- **Learning Guide for IUD Counseling Skills**
- **Learning Guide for IUD Clinical Skills**

Each learning guide contains the steps or tasks performed by the counselor and clinician when providing IUD services. These tasks correspond to the information presented in relevant chapters of the *IUD Guidelines for Family Planning Service Providers*, 2nd ed. reference manual (**Chapter 2**: Counseling and **Chapter 7**: IUD Insertion and Removal) as well as in the training videotape. This facilitates participant review of essential information.

The **practice checklist** combines the learning guides and focuses only on the key steps in providing IUD services:

- **Practice Checklist for IUD Counseling and Clinical Skills**

The practice checklist is the same as the Checklist for IUD Counseling and Clinical Skills which the clinical trainer will use to evaluate each participant's performance at the end of the course.

The participant is not expected to perform all the steps or tasks correctly the first time s/he practices them. Instead the learning guides are intended to:

- Assist the participant in learning the correct steps and sequence in which they should be performed (**skill acquisition**)

- Measure progressive learning in small steps as the participant gains confidence and skill (**skill competency**)

Prior to using the **Learning Guide for IUD Clinical Skills**, the clinical trainer will review the entire process for counseling, insertion and removal with the participants using the videotape. In addition, each participant will have the opportunity to witness a counseling demonstration session or IUD insertion/removal using the ZOE pelvic model and/or to observe the activity being performed in the clinic with a client. Thus, by the time the group breaks up into pairs to begin practicing and rating each other's performance, each participant should be familiar with the processes for counseling and inserting/removing an IUD.

Used consistently, the learning guides and practice checklist enable each participant to chart her/his progress and to identify areas for improvement. Furthermore, the learning guides and practice checklist are designed to make communication (coaching and feedback) between the participant and clinical trainer easier and more helpful. When using either learning guide, it is important that the participant and clinical trainer work together as a team. For

example, **before** the participant attempts the skill or activity (e.g., IUD insertion) for the first time, the clinical trainer (or person rating the participant, if not the clinical trainer) should briefly review the steps involved and discuss the expected outcome. In addition, immediately **after** the skill or activity has been completed the clinical trainer or rater should meet with the participant. The purpose of this meeting is to provide **positive feedback** regarding learning progress and to define the areas (knowledge, attitude or practice) where improvement is needed in subsequent practice sessions.

Because the learning guides are used to assist in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible. The participant's performance of each step is rated on a three-point scale as follows:

1 **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

3 **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

Using the Learning Guides

- The **Learning Guide for IUD Counseling Skills** should be used initially during practice (simulated) counseling sessions using volunteers or with clients in real situations.

- The **Learning Guide for IUD Clinical Skills** is designed to be used primarily during the early phases of learning (i.e., skill acquisition) when participants are practicing with the anatomic (pelvic) model. Therefore, it does not include the steps involved in pre- and postinsertion counseling of clients. (If IUD insertion/removal training is conducted only with clients instead of using pelvic models, the clinical skills learning guide should be supplemented with relevant portions of the **Learning Guide for IUD Counseling Skills**.)

- Initially, participants can use the learning guides to follow the steps as the clinical trainer role plays counseling a client or demonstrates IUD insertion or removal using a pelvic model.

- Subsequently, during the classroom practice sessions, they serve as step-by-step guides for the participant as s/he performs the skill using pelvic models or counsels a volunteer "client." During this phase, participants work in teams with one "service provider" participant performing the skill or activity while the other participant uses the learning guide to rate the performance or prompt the "service provider" as necessary. During this initial learning phase, clinical trainer(s) will circulate to each group of participants to oversee how the learning is progressing and check to see that the participants are following the steps as outlined in the learning guides.

Using the Practice Checklist

As participants progress through the course and gain experience, dependence on the detailed learning guides decreases and they advance to using the condensed **Practice Checklist for IUD Counseling and Clinical Skills**. This guide focuses on **key** steps in the entire procedure.

Once participants become confident in performing the procedure using the pelvic model, they can use the practice checklist to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference **before** the participants begin providing services to clients.

For clinic practice sessions with clients, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the practice checklist to remind the "service provider" of any missed steps. During this phase the clinical trainer(s) is always present in the clinic to supervise the initial client encounter for each participant. Thereafter, depending on the circumstances, s/he circulates between groups of participants to be sure that there are no problems, coaching them as they perform the skill/activity.

Remember: It is the goal of this training that **every** participant perform **every** task or activity correctly with clients by the end of the course.

SAMPLE 6-5

LEARNING GUIDE FOR IUD *COUNSELING SKILLS*

(To be used by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1 **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

3 **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR IUD *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
COUNSELING (INSERTION)					
Initial Interview (Client Reception Area)					
1. Greet client respectfully and with kindness.					
2. Establish purpose of the visit and answer questions.					
3. Provide general information about family planning.					
4. Give the woman information about the contraceptive choices available and the benefits and limitations of each: • Show where and how the method is used. • Explain how the method works and its effectiveness. • Explain possible side effects and other health problems. • Explain the most common side effects.					
5. Explain what to expect during the clinic visit.					
Method-Specific Counseling (Counseling Area)					
6. Assure necessary privacy.					
7. Obtain biographic information (name, address, etc.).					
8. Ask the client about her reproductive goals (Does she want to space or limit births?) and need for protection against GTIs and other STDs.					

LEARNING GUIDE FOR IUD *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
9. Explore any attitudes or religious beliefs that either favor or rule out one or more methods.					
10. Discuss the client's needs, concerns and fears in a thorough and sympathetic manner.					
11. Help the client begin to choose an appropriate method.					
If Client Chooses an IUD					
12. Screen the client carefully to make sure there is no medical condition that would be a problem (complete Client Screening Checklist).					
13. Explain potential side effects and make sure that each is fully understood.					
Pre-Insertion Counseling (Examination/Procedure Area)					
14. Review Client Screening Checklist to determine if the IUD is an appropriate choice for the client and if she has any problems that should be monitored while the IUD is in place.					
15. Inform client about required physical and pelvic examinations.					
16. Check that client is within 7 days of onset of menstrual period.					
17. Check for pregnancy if beyond day 7. (Nonmedical counselors should refer client for further evaluation.)					
18. Describe the insertion procedure and what she should expect during the insertion and afterward.					
Postinsertion Counseling					
19. Teach client how and when to check for strings.					
20. Discuss what to do if the client experiences any side effects or problems.					
21. Provide followup visit instructions.					
22. Remind client of 10-year effective life of the Copper T 380A IUD.					
23. Assure client she can return to the same clinic at any time to receive advice or medical attention and, if desired, to have the IUD removed.					
24. Ask the client to repeat instructions.					
25. Answer client questions.					

LEARNING GUIDE FOR IUD *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
26. Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.					

LEARNING GUIDE FOR IUD *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
COUNSELING (REMOVAL)					
Preremoval Counseling (Client Reception Area)					
1. Greet client respectfully and with kindness.					
2. Establish purpose of visit and answer any questions.					
Method-Specific Counseling (Counseling Area)					
3. Ask client her reason for removal and answer any questions.					
4. Ask client about her reproductive goals (Does she want to continue spacing or limiting births?) and need for protection against GTIs and other STDs.					
5. Describe the removal procedure and what she should expect during the removal and afterward.					
Postremoval Counseling					
6. Discuss what to do if client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).					
7. Ask client to repeat instructions.					
8. Answer any questions.					
9. If client wants to continue spacing or limiting births using another method, review general and method-specific information about family planning methods.					
10. Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.					
11. Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.					

SAMPLE 6-6

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*

(To be used by **Participants**)

Rate the performance of each step or task observed using the following rating scale:

1 **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

3 **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
CLIENT ASSESSMENT						
1. Greet client respectfully and with kindness.						
2. Determine that client has been counseled for insertion procedure.						
3. Take a reproductive health history. Ask for and record the following information to determine if the IUD is an appropriate choice for the client: • Date of last menstrual period, menstrual interval (days) and bleeding pattern • Parity, pregnancy outcomes and date of last pregnancy • History of ectopic pregnancy • Severe dysmenorrhea (painful periods) • Severe anemia (Hb < 9 g/dl or HCT < 27) • Recent history of sexually transmitted genital tract infections (GTIs), PID (in last 3 months) or other STDs (HBV/HIV/AIDS) • Multiple sexual partners (either partner) • Known or suspected cancer of genital tract						
Abdominal Examination						
4. Check that client has recently emptied her bladder and washed and rinsed her genital area if necessary.						
5. Tell client what is going to be done and encourage her to ask questions.						
6. Help client onto examination table.						
7. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
8. Palpate abdomen and check for lower abdominal, especially suprapubic, tenderness and masses or other abnormalities.						
Pelvic Examination						
9. Drape woman appropriately for pelvic exam.						
10. Provide adequate light to see cervix.						
11. Open high-level disinfected instrument pan or sterile pack without touching instruments.						
12. Put new examination or high-level disinfected surgical gloves on both hands.						
13. Arrange instruments and supplies on high-level disinfected or sterile tray.						
14. Inspect external genitalia and urethral opening.						
15. Palpate Skene's and Bartholin's glands for tenderness or discharge.						
16. Insert vaginal speculum.						
17. Perform speculum exam: • Check for vaginal lesions or discharge. • Inspect cervix. • Obtain vaginal and cervical and/or urethral specimens for microscopic examination if indicated (and testing is available).						
18. Gently remove speculum and either set it aside in kidney basin or place in 0.5% chlorine solution for 10 minutes for decontamination if another high-level disinfected speculum is available for use.						
19. Perform bimanual exam: • Determine if there is cervical motion tenderness. • Determine size, shape and position of uterus. • Rule out pregnancy or any uterine abnormality. • Check for enlargement or tenderness of adnexa.						
20a. If performing rectovaginal exam, keep gloves on and go to **steps 21a&21b**.						
20b. If **not** performing rectovaginal exam, immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If disposing of gloves, place in leakproof container or plastic bag. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.						
21a. Perform rectovaginal exam only if: • Position or size of uterus is questionable. • Possible mass behind the uterus.						

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*					
STEP/TASK	**CASES**				
21b. After completing rectovaginal exam, immerse both gloved hands in 0.5% chlorine solution, remove gloves by turning inside out and dispose of gloves in leakproof container or plastic bag.					
22. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
Microscopic Examination (if indicated and available)					
23. Test specimen with pH tape.					
24. Prepare saline and KOH wet mounts.					
25. Identify: • Vaginal epithelial cells • Trichomoniasis (if present) • Monilia (if present) • Clue cells (if present)					
26. Prepare Gram's stain (if indicated and available) and identify: • WBC (polymorphonuclear white cells) • Gram-negative intracellular diplococci (GNID) (if present)					
27. If microscopic exam done, wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
INSERTION					
Pre-Insertion Tasks					
1. Tell client what is going to be done and encourage her to ask questions.					
2. Load Copper T 380A in sterile package: • Partially open package and bend back white backing flaps. • Put white rod inside inserter tube. • Place package on flat surface. • Slide I.D. card underneath arms of the IUD. • Hold tips of IUD arms and push on the inserter tube to start bending arms. • When arms touch sides of inserter tube, pull tube away from the folded arms of IUD. • Elevate inserter tube and push and rotate to catch tips of arms in tube. • Push folded arms into inserter tube to keep them fixed in the tube.					
Insertion					
3. Put new examination or high-level disinfected surgical gloves on both hands.					
4. Insert vaginal speculum to see the cervix.					

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
5. Apply antiseptic solution two times to the cervix, especially the os, and vagina.						
6. Gently grasp cervix with tenaculum.						
7. While gently pulling on the tenaculum and without touching side walls of vagina or speculum blades, gently pass sound through cervix to the top of the uterus.						
8. Confirm whether the position of the uterus is anterior or posterior. Remove sound.						
9. Determine depth of uterine cavity.						
10. Set depth gauge to measured uterine depth with IUD still in sterile package, then completely open package.						
10a. Check to be sure the folded arms and the depth gauge are lying flat against the card.						
11. Remove loaded inserter tube without touching anything that is not sterile; be careful not to push the white rod toward IUD.						
12. Hold blue depth gauge in horizontal position. While gently pulling on tenaculum, pass loaded inserter tube through the cervix until depth gauge touches cervix or resistance is felt.						
13. Hold tenaculum and white rod stationary in one hand.						
14. Release arms of Copper T 380A IUD using **withdrawal** technique (pull inserter tube toward you until it touches thumb grip of white rod).						
15. Remove white rod and carefully push in on the inserter tube until slight resistance is felt.						
16. Partially withdraw the inserter tube and cut IUD strings to 3–4 cm length.						
17. Remove inserter tube.						
18. Gently remove the tenaculum and place in 0.5% chlorine solution for 10 minutes for decontamination.						
19. Examine cervix and if there is bleeding at the tenaculum puncture site(s), place cotton (or gauze) swab over bleeding and apply gentle pressure for 30–60 seconds.						
20. Gently remove speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.						
Postinsertion Tasks						

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
21. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.						
22. Dispose of waste materials such as cotton balls or gauze by placing in a leakproof container or plastic bag.						
23. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If disposing of gloves, place in leakproof container or plastic bag. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.						
24. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						
25. Check to be sure client is not having excessive cramping and answer any questions.						
26. Complete IUD card and record in client record.						
REMOVAL OF THE COPPER T 380A IUD						
1. Greet client respectfully and with kindness.						
2. Check to be sure client has emptied her bladder and washed and rinsed her genital area if necessary.						
3. Tell the client what is going to be done and encourage her to ask questions.						
4. Help client onto examination table.						
5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						
6. Put new examination or high-level disinfected surgical gloves on both hands.						
7. Perform bimanual exam: • Determine if there is cervical motion tenderness. • Determine size, shape and position of uterus. • Palpate adnexa for abnormalities or enlargements.						
8. Insert vaginal speculum to see cervix and IUD strings.						
9. Apply antiseptic solution two times to the cervix, especially the os, and vagina.						
10. Grasp strings close to the cervix with hemostat or other narrow forceps.						
11. Pull on strings slowly but firmly to remove IUD.						

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
12. Show IUD to client.						
13. Immerse IUD in 0.5% chlorine solution and dispose of in a leakproof container or plastic bag.						
14. Gently remove speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.						

LEARNING GUIDE FOR IUD *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
Postremoval Tasks						
15. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.						
16. Dispose of waste materials by placing in leakproof container or plastic bag.						
17. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If disposing of gloves, place in leakproof container or plastic bag. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.						
18. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						
19. Record IUD removal in client record.						

SAMPLE 6-7

INSTRUCTIONS FOR USING THE CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS

USING THE CHECKLIST

The **Checklist for IUD Counseling and Clinical Skills** is used by the clinical trainer to evaluate each participant's performance in providing IUD services to clients (i.e., counseling, client screening, infection prevention practices, insertion and removal). This checklist is derived from the information provided in the IUD reference manual as well as that in the videotape and the learning guides. Unlike the learning guides, which are quite detailed with the counseling activities and insertion and removal skills separated, the checklist focuses on the **key** steps in the entire process.

Criteria for satisfactory performance by the participant are based on the knowledge, attitudes and skills set forth in the reference manual and learning guides.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by trainer

Evaluation of the **counseling skills** of each participant may be done with clients. It may, however, also be accomplished through observation during role plays with volunteers or clients in real situations at any time during the course.

Evaluation of **clinical skills** usually will be done during the last 3 days of the course (depending on class size and client caseload). In a participant's first few cases, it is not mandatory (or even possible) for the trainer to observe the participant perform a procedure from beginning to end. For example, early on s/he may watch the participant load the IUD in the sterile package in one case, insert the IUD in another and decontaminate instruments in yet a third. What is important is that each participant demonstrates the steps or tasks at least once for feedback and coaching prior to the final evaluation. (If a step or task is not done correctly, the participant should repeat the entire skill or activity sequence, **not** just the incorrect step.) In addition, it is recommended that the clinical trainer not stop the participant at the incorrect step unless the safety of the client is at stake. If it is not, the clinical trainer should allow her/him to finish the skill/activity before providing coaching and feedback on her/his overall performance.

In determining whether the participant is qualified, the clinical trainer(s) will observe and rate the participant's performance on each step of a skill or activity. The participant must be rated "Satisfactory" for each skill/activity group covered in the checklist in order to be evaluated as qualified.

Finally, during the course, it is the clinical trainer's responsibility to observe each participant's overall performance in providing IUD services. Only by doing this can the clinical trainer assess the way the participant uses what s/he has learned (e.g., her/his attitude towards clients). This provides a key opportunity to observe the impact of the participant's **attitude** on clients—a critical component of quality service delivery.

Qualification

The number of procedures each participant needs to observe, assist with and perform will vary depending on her/his previous training and experience as well as how the current training is being conducted (e.g., are models being used

for initial skill acquisition). The number of clinical cases needed must be assessed on an individual basis; there is no "magic number" of cases which automatically makes a person qualified to provide IUD services.

When anatomic models are used for initial skill acquisition, nearly all participants will be judged to be competent after only two to four cases. Proficiency, however, invariably requires additional practice. Therefore, when training participants who will become **new** IUD service providers (i.e., participants without prior training or experience), each participant may need to provide IUD services to at least 5 to 10 clients in order to "feel confident" about her/his skills. Thus, in the final analysis, the judgement of a skilled clinical trainer is the most important factor in determining competence (i.e., whether the participant is qualified).

The goal of this training is to enable **every** participant to achieve competency (i.e., be qualified to provide IUD services). Therefore, if additional practice in, for example, counseling or IUD insertion is needed, sufficient extra cases should be allocated during the course to ensure that the participant is qualified. Finally, once qualified, each participant should have the opportunity to apply her/his new knowledge and skills as soon as possible. Failure to do so quickly leads to loss of **provider confidence** and ultimately **loss of competence**.

SAMPLE 6-8

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS

(To be completed by **Clinical Trainer**)

Place a "✓" in case box if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task or skill not performed by participant during evaluation by clinical trainer

PARTICIPANT_____ **Course Dates** _____

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS						
STEP/TASK	**CASES**					
IUD INSERTION						
Pre-Insertion Counseling						
1. Greets client respectfully and with kindness.						
2. Asks woman about her reproductive goals and need for protection against GTIs and other STDs.						
3. If IUD counseling not done, arranges for counseling prior to performing procedure.						
4. Determines that the woman's contraceptive choice is the IUD.						
5. Reviews Client Screening Checklist to determine if the IUD is an appropriate choice for the client.						
6. Assesses woman's knowledge about the IUD's major side effects.						
7. Is responsive to client's needs and concerns about the IUD.						
8. Describes insertion procedure and what to expect.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
INSERTION OF COPPER T 380A IUD						
Pre-Insertion Tasks						
1. Obtains or reviews brief reproductive health history.						

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	**CASES**				
2. Checks that client has recently emptied her bladder and washed and rinsed her genital area if necessary.					
3. Tells client what is going to be done and encourages her to ask questions.					
4. Washes hands thoroughly and dries them.					
5. Palpates abdomen and checks for lower abdominal, especially suprapubic, tenderness and masses or other abnormalities.					
6. Puts new examination or high-level disinfected surgical gloves on both hands.					
7. Arranges instruments and supplies on high-level disinfected or sterile tray.					
8. Performs speculum examination.					
9. Collects vaginal and cervical (urethral) specimens if indicated.					
10. Removes speculum and either sets aside on instrument tray or places in 0.5% chlorine solution for 10 minutes for decontamination if another high-level disinfected speculum is available for use.					
11. Performs bimanual examination.					
12. Performs rectovaginal examination if indicated. • Immerses both gloved hands in 0.5% chlorine solution. • Removes gloves by turning inside out and disposes of gloves in leakproof container or plastic bag.					
13. If **not** performing rectovaginal examination, immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out. • If disposing of gloves, places in leakproof container or plastic bag. • If reusing surgical gloves, removes gloves by turning inside out and submerges in 0.5% chlorine solution for 10 minutes for decontamination.					
14. Washes hands thoroughly and dries them.					
15. Performs microscopic examination if indicated (and equipment is available).					
16. If microscopic exam done, washes hands thoroughly and dries them.					
17. Loads Copper T 380A in sterile package.					
IUD Insertion					
18. Puts new examination or high-level disinfected surgical gloves on both hands.					
19. Inserts vaginal speculum to see cervix.					

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	**CASES**				
20. Applies antiseptic solution two times to cervix, especially the os, and vagina.					
21. Gently grasps cervix with tenaculum.					
22. Sounds uterus using no-touch technique.					
23. Inserts the Copper T 380A IUD using the **withdrawal** technique.					
24. Cuts IUD strings to 3–4 cm in length.					
25. Gently removes tenaculum and speculum and places in 0.5% chlorine solution for 10 minutes for decontamination.					
Postinsertion Tasks					
26. Before removing gloves, places all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
27. Disposes of waste materials in leakproof container or plastic bag.					
28. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning inside out. • If disposing of gloves, places in leakproof container or plastic bag. • If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination.					
29. Washes hands thoroughly and dries them.					
30. Completes client record.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTINSERTION COUNSELING					
1. Teaches client how and when to check for strings.					
2. Discusses what to do if client experiences any side effects or problems.					
3. Provides followup visit instructions and answers any questions.					
4. Assures client that she can have the IUD removed at any time.					
5. Observes client for at least 15 to 20 minutes before sending her home.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
IUD REMOVAL					
Preremoval Counseling					

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	**CASES**				
1. Greets client respectfully and with kindness.					
2. Asks client her reason for removal and answers any questions.					
3. Reviews client's reproductive goals and need for protection against GTIs and other STDs.					
4. Describes the removal procedure and what to expect.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
REMOVAL OF COPPER T 380A IUD					
1. Checks to be sure client has emptied her bladder and washed and rinsed her genital area if necessary.					
2. Tells client what is going to be done and encourages her to ask questions.					
3. Washes hands thoroughly and dries them.					
4. Puts new examination or high-level disinfected surgical gloves on both hands.					
5. Performs bimanual exam.					
6. Inserts vaginal speculum to see cervix and IUD strings.					
7. Applies antiseptic solution two times to the cervix, especially the os, and vagina.					
8. Grasps strings close to cervix and pulls slowly but firmly to remove IUD.					
9. Shows IUD to client.					
10. Immerses IUD in 0.5% chlorine solution and disposes of in leakproof container or plastic bag.					
11. Gently removes speculum and places in 0.5% chlorine solution for 10 minutes for decontamination.					
Postremoval Tasks					
12. Before removing gloves, places all instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
13. Disposes of waste materials in leakproof container or plastic bag.					

CHECKLIST FOR IUD COUNSELING AND CLINICAL SKILLS					
STEP/TASK	**CASES**				
14. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out. • If disposing of gloves, places in leakproof container or plastic bag. • If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination.					
15. Washes hands thoroughly and dries them.					
16. Records IUD removal in client record.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTREMOVAL COUNSELING					
1. Discusses what to do if client experiences any problems and answers any questions.					
2. Counsels client regarding new contraceptive method, if desired.					
3. Helps client obtain new contraceptive method or provides temporary (barrier) method until method of choice can be started.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

PARTICIPANT IS **G QUALIFIED G NOT QUALIFIED** TO DELIVER IUD SERVICES, BASED ON THE FOLLOWING CRITERIA:

! Score on Midcourse Questionnaire _____% (Attach Answer Sheet)

! Counseling and Clinical Skills Evaluation: **G** Satisfactory **G** Unsatisfactory

! Provision of services (practice): **G** Satisfactory **G** Unsatisfactory

Trainer's Signature_____ Date_____

SEVEN

DEVELOPING CLINICAL SKILLS

INTRODUCTION

Clinical training places the participant with an experienced clinician-trainer in a real or simulated clinical setting where the participant can observe and practice the skills required to reach an established standard of performance. Clinical training, sometimes called a clinical tutorial, preceptorship or practice session, requires an intensive, usually one-on-one, interaction between the clinical trainer and the participant. This interaction is needed to help the participant:

- learn and apply specific knowledge and positive attitudes, and
- develop clinical and problem-solving skills.

Clinical skills are developed through a process known as **coaching**. The coaching process includes three closely related phases:

- demonstration of the clinical skill by the trainer;
- practice of the skill by the participant under the supervision of the trainer, first on models and then with clients; and
- evaluation of the participant's skill competency by the trainer.

Although much has been written about classroom training, less guidance is available to clinicians who wish to improve their clinical training and coaching skills. The result of inadequate clinical training has been that clinicians can name every bone and muscle in the body and quote from hundreds of medical studies, but they may not be able to perform medical procedures in a caring, skillful manner. Unacceptable rates of surgical complications and high levels of client dissatisfaction can result when knowledge and practical skills are not integrated. The "see one, do one, teach one" approach, in which a clinician is **thought** to be qualified to perform a clinical procedure after one observation, and then be able to train others, is **not acceptable**.

Coaching helps to ensure that participants will be competent in the clinical skills being learned. This chapter will explore the process of transferring skills from proficient service providers to those attending training.

Chapter Objective After completing the chapter, the participant will be able to demonstrate a clinical skill and coach skill development.

Enabling Objectives To attain the chapter objective, the participant will:

- Identify the three phases in the skill transfer and assessment process
- Identify the characteristics of an effective trainer/coach
- Coach development of a skill
- Use anatomic models for clinical training
- Conduct an effective clinical demonstration

SKILL TRANSFER AND ASSESSMENT: THE COACHING PROCESS

Situation 1: You are observing a new clinical trainer as she conducts a clinical skills course. During her first demonstration of how to perform a clinical skill she discusses each step in the learning guide and then asks for questions. When there are no questions, she instructs the participants to work in small groups to practice the skill on an anatomic model. While checking on their progress, the trainer notices that most of the participants are having difficulties. What should the trainer have done to prevent these problems from occurring?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

As mentioned above, the process of learning a clinical skill within the coaching process has three basic phases: demonstration, practice and evaluation. These three phases can be broken down further into the following steps:

- First, during interactive classroom presentations, **explaining** the skill or activity to be learned
- Next, using a videotape or slide set, **showing** the skill or activity to be learned
- Following this, **demonstrating** the skill or activity using an anatomic model (if appropriate) or role play (e.g., counseling demonstration)

- Then, allowing the participants to **practice** the demonstrated skill or activity with an **anatomic model** or in a simulated environment (role play) as the trainer functions as a coach

- After this, **reviewing** the practice session and giving constructive feedback

- After adequate practice, **assessing** each participant's performance of the skill or activity on models or in **a simulated situation**, using the competency-based checklist

- After competence is gained with models or practice in a simulated situation, having participants begin to **practice** the skill or activity with clients under a clinical trainer's guidance

- Finally, **evaluating** the participant's ability to perform the skill according to the standardized procedure as outlined in the competency-based checklist (See **Chapter 6** for more information on evaluation of clinical skills.)

Table 7-1 shows the three phases of the coaching process used to help participants develop clinical skills successfully. Note how the roles shift during the process. During initial skill acquisition, the trainer demonstrates the skill as the participant observes. As the participant practices the skill, the trainer functions as a coach and observes and assesses performance. When demonstrating skill competency, the participant is now the person performing the skill as the trainer evaluates performance.

Table 7-1. Coaching in Clinical Training

ROLES	LEVEL OF PERFORMANCE		
	Skill Acquisition	**Skill Acquisition/ Competency (with models)**	**Skill Competency (with clients)**
Clinical Trainer	Demonstrates skill/activity	Coaches the participant and assesses participant performance	Evaluates participant performance
Participant	Observes the demonstration	Practices and performs the skill/activity	Performs the skill/ activity
The participant progresses from skill acquisition to skill competency using anatomic models. After the participant reaches skill competency using a model, the process begins again as the skill/activity is performed with clients.			

CHARACTERISTICS OF AN EFFECTIVE TRAINER AND COACH

Situation 2: You are conducting a clinical skills course. During the last day of the course one of the service providers approaches you and indicates an interest in becoming a trainer just like you. He is aware that another clinical skills course is being taught in 2 weeks and asks if he can cotrain with you to become a clinical trainer. How do you answer him?

Write your response on a piece of paper and then compare your response to the one found at the end of this chapter.

People learn best by observing the correct **modeling** of a clinical procedure by an expert practitioner. Approved, agreed upon **standards of performance** (see **Chapter 1**) are essential to the learning process, particularly when assessing progress in learning a new skill. The clinical trainer must accurately demonstrate the approved technique for carrying out the clinical skill or procedure so that the participant has a clear picture of the expected performance.

Medical practice, especially performing surgical procedures, is an art that varies from clinician to clinician. Clinicians often develop personal styles or approaches in which they take great pride, much like the personal styles exhibited by artists or athletes. These individual differences in approach are acceptable (and are necessary for progress) so long as basic quality standards are observed and the welfare of the client is not jeopardized. For clinical training purposes, however, it is important that the participant be presented with a performance model that is:

- **Consistent** among clinical trainers
- **Practical**, given local conditions
- As **simple** and **easy to learn** as possible

Participants learn new skills most easily when they are highly motivated to learn and are not overwhelmed by feelings of anxiety and fear. Adults often experience fear when learning new tasks, especially if they feel their self-esteem or image with colleagues will be damaged, or if previous learning experiences, in medical school for example, have been embarrassing or threatening.

Participants associate new skills or techniques they are learning with the entire climate in which they are learning them. If the learning environment is **pleasant, supportive and enhances self-esteem, the participant is more likely to learn and use the skills**. If the learning environment or the

behavior of the clinical trainer produces feelings of discomfort or stress, however, participants may try to relieve the discomfort by discounting the quality of the training and the relevance of the skill. Participants may also use other defense mechanisms that restrict learning.

Motivation to learn can be increased by creating an environment that boosts participants' confidence in their ability to learn.

An effective clinical trainer:

- Is **proficient** in the skills to be taught
- **Encourages** participants in learning new skills
- Promotes **open (two-way) communication**
- Provides **immediate feedback**:
    - Informs participants whether they are meeting the objectives
    - Does not allow a clinical task or skill to be performed incorrectly
    - Gives positive feedback as often as possible
    - Avoids negative feedback and instead offers specific suggestions for improvement
- Recognizes that clinical training can be stressful and knows how to **regulate participant as well as trainer stress**:
    - Uses appropriate humor
    - Observes participants and watches for signs of stress
    - Provides regular breaks during training sessions
    - Provides for changes in the training routine
    - Focuses on participant success instead of failure

The characteristics of an **effective coach** are the same as those of an **effective clinical trainer**. Additional characteristics especially important include:

- Being patient and supportive
- Providing praise and positive reinforcement

- Correcting participant errors while maintaining participant self-esteem
- Listening and observing

To understand fully the role of the coach, it is helpful to compare the **do's** and **don'ts** of effective coaching. The effective coach involves all participants in the learning process and provides them with positive feedback. The ineffective coach is controlling, avoids involving the participants and typically fails to provide positive feedback. A comparison of the **effective** and **ineffective** coach is presented below.

The Effective Coach...	**The Ineffective Coach...**
Focuses on the practical	Focuses on the theoretical
Encourages working together (collegial relationship)	Maintains a distance (status is above the participants)
Works to reduce stress	Often creates stress
Fosters two-way communication	Uses one-way communication
Is a facilitator of learning	Acts as the authority or the only source of knowledge

Coaching is appropriate when:

- The training needs assessment reveals that service providers lack specific skills needed to carry out their jobs competently.
- Specific performance standards have been established for the skills or procedures.
- Experienced clinical trainers are available to demonstrate and teach the skills needed to reach the established performance standards.
- Facilities, instruments and anatomic models are available for practicing the skills.
- Participants will have the resources and opportunities to apply newly acquired skills in their work situation **soon** after being trained.

COACHING

Situation 3: You are preparing to conduct a clinical training skills course. When talking to a clinical supervisor about one of her nurses attending the course to become a clinical trainer, you are asked what is meant by the term "coach." How would you describe the role of the coach?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Health professionals conducting clinical training courses are continually changing roles. They are **trainers** or **instructors** when presenting illustrated lectures and giving classroom demonstrations. They act as **facilitators** when conducting small group discussions and using role plays and case studies. Once they have demonstrated a clinical procedure, they then shift to the role of **coach** as the participants begin practicing.

Coaching is a training technique which involves the use of active listening, questioning, positive feedback and problem-solving skills to help create a positive learning climate. Coaching refers to a general philosophy or approach to training as well as a specific activity carried out during a training session in order to help a participant learn something new. Helping a participant, through coaching, to learn a new clinical skill is one of the most important roles of a clinical trainer. The clinical trainer as coach must lead the participant through the learning stages in a way that maintains and enhances self-esteem.

Communicating During Coaching

Active listening is a communication technique that enables a clinical trainer to stimulate open and frank exploration of ideas and feelings and establish trust and rapport with participants. It helps the clinical trainer clarify participant comments and enables the participant to be heard and understood. In **active listening**, the trainer accepts what is being said without making any value judgments, clarifies the ideas or feelings being expressed and reflects these back to participants.

The following are examples of active listening techniques:

- Stop talking and listen to the speaker.
- Restate the speaker's exact words.
- Paraphrase in your own words what the speaker said.
- Understand and reflect the **underlying feelings** of the speaker (identify the emotion).

- Identify with the speaker's emotions and state the implications of those feelings. ("If I could conduct training that well, I would be ecstatic.")

When actively listening, it is appropriate to ask nonleading questions such as, "Can you tell me more about that?" or "Help me understand what you said." It is also appropriate to ask for help as a part of active listening; for example, "I'm not sure I fully understand what you are saying," or "I'm confused as to whether you mean the doctor or the nurse. Can you explain more?"

Active listening does not include probing questions of a cross-examination type such as "Why did you do that?" or "What are you going to do about that?" Active listeners are not accusatory, nor do they ask questions that lead to only one answer. Active listening reflects what has been said and draws the participant out to expand further on the meaning or feelings. It also is a communication tool which can be used to shape learning and reinforce effective behavior in a positive way.

Everyone likes being heard and appreciated. Supportive comments from the clinical trainer **strengthen** and **reinforce** desired behavior.

Questioning is used in clinical training to assess the participant's knowledge and to teach problem solving. Clinicians, when interviewing clients, normally use two types of questions: **closed questions** that have a small range of answers (often *yes* or *no*); and **open questions** that allow a wide range of responses. Both types of questions are useful in assessing the participant's level of knowledge.

When using questioning to assess a participant's knowledge in a clinical situation, the clinical trainer should consider using different types of questions. Questions can range from those that ask for facts and information to questions that present new or hypothetical situations for consideration. Questions can also probe the depth of a participant's knowledge and understanding. They can even be used to assess decision-making skills. Examples of such questions are:

- **Factual questions**, beginning with *what, where* or *when*, that obtain information and begin discussion
- **Broadening questions** that assess additional knowledge

- **Justifying questions** that challenge ideas and assess depth of knowledge and understanding

- **Hypothetical questions** that explore new situations

- **Alternative questions** that assess decision-making skills

Questioning does **not** mean interrogating. The trainer should let participants know that the purpose of questioning is to help target instruction, not to berate and belittle them. Asking them what they know and what they want to learn will help assess their needs and focus training more precisely.

Feedback is essential throughout the coaching process, including before, during and after demonstrations, practice sessions and skill evaluations. Many clinical trainers find it difficult to acquire the skill of giving performance-enhancing feedback. Although the following guidelines for giving and receiving feedback may be helpful, trainers usually need practice to become more confident with this essential skill.

Guidelines for the clinical trainer to follow in **giving** feedback are:

- **Be timely.** Give your feedback soon after the event.

- **Be specific.** Describe specific behaviors and reactions, particularly those that the participant should keep and those that should be changed. (Consult the information recorded on the learning guide to help focus the feedback on key points.)

- **Be descriptive**, not judgmental. Describe the consequences of the behavior; do not judge the person.

- **Take responsibility for your own feedback.** Speak for yourself, not for others.

  Example (descriptive, specific feedback):

  "When you gave the injection of local anesthetic, you did not tell the client what to expect. I saw her wince and tense up, making it difficult for you to gain her cooperation later in the procedure."

  Example (judgmental, non-specific feedback):

  "You always seem to be in such a hurry that you completely ignore the client's needs."

Guidelines for the participant to follow in **receiving** feedback include:

- **Ask for it.** Find clinical trainers who will be direct. Ask them to be specific and descriptive.
- **Direct it.** If you need information to answer a question or to pursue a learning objective, ask for it.
- **Accept it.** Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.

Problem Solving

One of the main purposes of clinical training is to help service providers become confident, independent problem solvers. Each client and each clinical situation is unique. **Because one cannot hope to anticipate every problem the participant will encounter, teaching rote responses will not work.** Effective problem solving is based on the following steps:

- **Recognize** that there is a problem
- **Identify** the problem
- **Generate** alternative solutions to the problem
- **Choose** a solution to the problem
- **Implement** the chosen solution
- **Evaluate** the solution

Problem solving in clinical learning is similar to the process of clinical reasoning that all medical students are taught. A wide range of formats can be used for presenting clinical situations to enhance problem-solving capability such as:

- Written case studies
- Videotaped situations to trigger discussion
- Case presentations by participants based on their own experiences
- Discussion of practice cases during clinical training sessions

As in most training situations, **the more "here and now" the cases are, the more effective will be the problem-solving discussion**. The most effective way to teach problem solving is to use the participant's own clinical practice cases as the material to be discussed. For example, participants might have clinical practice cases in the morning and get together with the clinical trainer in a group in the afternoon. During the

discussion session, they would be asked to present any problem situations they encountered in the morning, and the group would then discuss alternative solutions to the problem.

Medical schools are finding that "problem-based learning" can replace many of the lecture-based classes that have been the traditional fixture of medical education. Both students and faculty who have been trained in problem-based learning find it a highly acceptable learning method.

Assessing Learning During the Coaching Process

The purpose of the coaching process is to assist those attending a course to develop specific clinical skills. It requires continual assessment of the participant (especially during practice sessions) in order to provide positive feedback and offer suggestions for improvement. It is through this assessment and feedback process that the participant begins to become competent at performing the skill.

For clinical skills training to be effective, participants must have a way to continually **assess** their progress in learning new skills. Using a **competency-based learning guide** during training enables participants to:

- Assess their skill level and learning needs when entering training
- Set realistic learning goals
- Assess their learning progress during training
- Receive useful, objective feedback from the clinical trainer and other participants
- Determine when they have mastered the skill or activity

Competency-based learning guides can be developed for any clinical activity or skill (e.g., counseling or inserting an IUD). Learning guides such as those presented in **Chapter 6** (**Samples 6-5 and 6-6**) provide a simple way for participants to chart their progress in mastering each skill area as they practice the procedure.

The clinical trainer also enhances participant learning by providing detailed and specific verbal **feedback** about individual performance. Each time the participant performs the procedure using an anatomic model or with a client, the trainer has **three** separate opportunities to provide feedback:

- **Before Practice.** The clinical trainer and participant meet briefly before each practice session to review participant performance (by checking the learning guide) in previous practice sessions. This pinpoints areas of strength and weakness. Before each practice

session, the trainer and participant also set learning goals specifying the skills that will receive special attention during the session.

- **During Practice.** The clinical trainer completes the learning guide during the practice session while observing the participant's performance. This step enables the trainer to give the participant feedback **after** the practice session. In addition, the clinical trainer may provide immediate specific verbal feedback to the participant on skills performed correctly. Corrective feedback during procedures with clients who are awake or only slightly sedated should be limited to errors that could harm or cause discomfort to the client. Excessive feedback in the procedure room, especially negative comments, can create anxiety for both the participant and the client.

- **After Practice.** It is essential that the postpractice feedback session take place as soon as possible after the practice session. In this feedback session, the clinical trainer first asks the participant to share observations about the procedure in order to encourage self-assessment and good problem-solving behavior. Following the participant's self-assessment, the clinical trainer provides feedback based on what was observed and recorded in the learning guide. Again, it is important initially to concentrate on positive feedback before pointing out ways in which performance could be improved.

Table 7-2 summarizes what happens in the coaching process before, during and after a demonstration or practice session as the clinical trainer coaches the participant from beginning skill acquisition to skill competency.

Table 7-2. Using the Coaching Process for Learning and Developing Skills

DEMONSTRATION OR PRACTICE SESSION	LEVELS OF PERFORMANCE		
	Skill Acquisition	**Skill Acquisition/Competency**	**Skill Competency**
Before	Clinical trainer (CT) • Provides an overview of the skill/activity • Uses audiovisual and other training aids • Reviews the learning guide • Asks for questions	Clinical trainer • Reviews steps/tasks in the learning guide • Answers questions about the skill/activity CT and participant discuss the role of the clinical trainer as coach and evaluator	Clinical trainer • Discusses previous practice sessions with participant • Reviews the checklist Both discuss the role of the clinical trainer as evaluator
During	Clinical trainer • Demonstrates each step of the skill/activity • Uses audiovisual and other training aids Participant • Observes using the learning guide Both • Two-way interaction takes place	Both • Participant performs the procedure while coach observes using the learning guide • Participant asks questions as needed while coach provides positive feedback and offers suggestions • CT observes and evaluates participant performance on models using the checklist	Participant performs the procedure CT observes and evaluates participant performance using the checklist
After	Both • Discuss the skill/activity • Review the learning guide CT answers any questions Participant is ready to practice	Participant • Shares feelings about positive aspects of the practice session • Offers suggestions for self-improvement Both review the steps in the learning guide Clinical trainer provides positive feedback and offers suggestions for improvement Both set goals for additional practice if needed CT determines if participant is competent to move from models to clients	Participant • Shares feelings about positive aspects of the clinical session • Offers suggestions for self-improvement Both • Review the steps in the checklist Clinical trainer • Provides positive feedback and offers suggestions for improvement • Determines if participant is qualified or if additional practice is needed

USING ANATOMIC MODELS FOR CLINICAL TRAINING

Situation 4: During the opening session of a clinical skills course, one of the physicians asks why she needs to learn the skill on an anatomic model. She has always learned skills by watching a skilled clinician and then trying the procedure herself. What is your response?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Training clinicians in complex skills, such as performing a minilaparotomy or removing Norplant implants, requires that participants carefully observe skilled clinical trainers and practice the skills repeatedly. Skills acquisition with clients, however, exposes the clients to a potentially increased risk of complications and discomfort during the procedure. To overcome this problem, **anatomic models** often are used to **demonstrate** clinical procedures and to allow participants to **learn** and **practice** these skills without harming clients (**humanistic approach**).

The use of anatomic models enhances skill development by providing participants with the opportunity to practice a skill or specific portion of a procedure repeatedly until they are comfortable with it and have achieved some degree of proficiency (i.e., can perform the skill efficiently). As stated in **Chapter 1**, clinical training with models has been shown to reduce significantly the number of IUD clients needed for clinicians to become competent in IUD insertion.

Advantages of Using Anatomic Models

The **advantages** of using anatomic models include:

- Clients are not harmed or inconvenienced if a mistake is made.
- The demonstration or practice can be stopped at any time for further explanation or correction by the clinical trainer.
- Several participants can practice simultaneously, reducing training time.
- Difficult tasks (e.g., using the tubal hook to identify and bring the fallopian tubes out of the pelvic cavity for a minilaparotomy) can be practiced repeatedly on a pelvic model without actually performing surgery on a client.
- Practice is not limited to the clinic or operating room, or to the time when clients are scheduled.

- Practice of a sequence of steps or skill can be repeated at any time and as often as needed.

- Clinical training is possible even when client caseload is low, because fewer cases are needed for participants to attain skill competency.

- Training time is reduced.

Any simulation, however, is only an approximation of the real situation. To enhance learning, it is important that the **anatomic models and the simulated setting be as close to the real experience as possible**. Where significant differences exist between working with a model and a real client, these differences should be pointed out to the participant. For example, the "subcutaneous tissue" on the training arm model used for Norplant implants training is less pliable than that of a human arm. Participants need to know that it is easier to insert the trocar too deep in a client's arm than on the model.

To use a model effectively, the clinical trainer must be as proficient in performing the procedure on the model as with a client. This requires considerable practice with the model, including learning how to assemble and disassemble it.

To be effective, participants should have frequent opportunities to work with the models using the actual instruments in a realistic setting. Furthermore, the procedure should be performed numerous times using the relevant sections of the clinical skills learning guide to assure that the standard approach is being followed. Finally, practice with the model should continue until **skill competency** and some degree of **skill proficiency** have been demonstrated by the participant. Then, **and only then**, should the participant be permitted to perform the procedure with a client.

When using models in clinical training, it is important that:

- Sufficient models are available (usually one model for two or, at most, three participants).

- The model is positioned as if it were a client. This enables the participant to perform the skill/activity as it will be performed with clients.

- Conditions, such as instruments used to perform the procedure and recommended infection prevention practices, duplicate the real situation as much as possible.

- The model is treated gently and with the same respect given an actual client.

The following example illustrates how the use of models can facilitate learning a clinical skill such as insertion of Norplant implants.

Using Anatomic Models in Norplant Implants Training

In a 3-day training course on insertion and removal of Norplant implants, use of the subdermal implant training arm model is an essential component. During **day one** of the course, following a complete demonstration on the model of how to insert Norplant capsules, participants are taught how to assemble and use the model. They then practice inserting Norplant capsules on the model following the steps outlined in the *Learning Guide for Norplant Implants Clinical Skills* developed specifically for this procedure. Coaching is provided by the clinical trainer throughout the practice session.

At the end of the first day, participants take the training arm model and insertion equipment to their hotel or home for continued practice. At the beginning of **day two** of the course, the clinical trainers assess their skill in inserting Norplant capsules using the checklist. Those who are rated "competent" in insertion on the model are permitted to begin working with a client under guidance of the clinical trainer. Those who have **not** been rated "competent" continue to practice on the model arm until competency is achieved. This sequence is repeated for training participants in the removal of Norplant implants.

CONDUCTING AN EFFECTIVE CLINICAL DEMONSTRATION

Situation 5: You are working with a new clinical trainer during his first clinical skills course. He is reviewing the information in the Clinical Training Skills reference manual and notices that it says "never demonstrate the skill or activity incorrectly." He asks you why. How do you answer him?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

When introducing a new clinical skill, the clinical trainer can use a variety of methods to demonstrate the procedure. For example:

- Show **slides** or a **videotape** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.

- Use **anatomic models** such as pelvic or Norplant implants training arm models to demonstrate a procedure and skills.

- Perform a **role play** in which a participant simulates a client and responds much as a real client would.

- Demonstrate the procedure with **clients** in the operating or procedure room.

Starting with demonstrations that do not involve clients enables the clinical trainer **to take ample time, stop and discuss key points** and **repeat difficult steps without endangering the health or comfort of a client**.

Whatever methods are used to demonstrate the procedure, the clinical trainer should set up the activities using the "**whole-part-whole**" approach:

- Demonstrate the **whole procedure** from beginning to end to give the participant a visual image of the entire procedure or activity.

- **Isolate or break down the procedure or activity** into parts (e.g., pre-operative counseling, getting the client ready, pre-operative tasks, performing the procedure, etc.) and allow practice of the individual parts of the procedure or activity.

- Demonstrate the **whole procedure** again and then allow participants to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure using anatomic models (or with clients if appropriate), the clinical trainer should use the following guidelines:

- Before beginning, **state the objectives** of the demonstration and point out what the participants should do (e.g., interrupt with questions, observe carefully, etc.).

- Make sure that **everyone can see** the steps involved.

- **Never** demonstrate the skill or activity incorrectly.

- Demonstrate the procedure in as **realistic** a manner as possible, using actual instruments and materials in a simulated clinical setting.

- Include **all steps** of the procedure in the **proper sequence** according to the approved performance standards. This includes demonstrating "nonclinical" steps such as pre- and postoperative counseling, communication with the client during surgery, use of recommended infection prevention practices, etc.

- During the demonstration, explain to participants what is being done—especially any difficult or hard-to-see steps.

- **Ask questions** of participants to keep them involved, such as, "What should I do next?" or "What would happen if...?"

- **Encourage** questions and suggestions.

- **Take enough time** so that each step can be observed and understood. Remember that the objective of the demonstration is for the participant to learn the skills, **not** for the clinical trainer to show dexterity and speed.

- **Use equipment and instruments properly** and make sure participants see clearly how they are handled.

The essential elements of an effective clinical demonstration are summarized in the self-assessment guide presented in **Sample 7-1** at the end of the chapter. **Sample 7-2** is a self-assessment guide for coaching skill development.

In addition, participants should use a clinical skills **learning guide** (see **Chapter 6**) to observe the clinical trainer's performance during the initial demonstration. Doing this:

- Familiarizes the participant with the use of competency-based learning guides

- Reinforces the standard way of performing the procedure

- Communicates to participants that the clinical trainer, although very experienced, is not perfect and can accept constructive feedback on performance of the clinical skill

As the role model the participants will follow, the clinical trainer must practice what is demonstrated. Therefore, it is essential that the clinical trainer use the **approved, standard method**, as detailed in the learning guide, when demonstrating a procedure or skill with clients. During the demonstration, the clinical trainer should also provide supportive behavior and cordial, effective communication with the client and staff to reinforce the desired outcome.

SUMMARY

The skill development process presented in this chapter is based on a three-part coaching process:

- Demonstration of the skill by a proficient trainer
- Skill practice under the supervision of a coach
- Evaluation of the participant's skill competency according to the standards presented in the performance checklist. (See **Chapter 6** for a full discussion of using competency-based assessment instruments.)

Many of the characteristics of an effective coach are the same as those of an effective clinical trainer. The effective trainer/coach must have good communication skills, including the use of active listening, questioning techniques and feedback, in order to develop participants' clinical skills fully. The clinical trainer also must be able to teach problem-solving skills, assess learning during the coaching process and conduct an effective clinical demonstration, often using anatomic models. Through intensive, one-on-one interaction, the clinical trainer guides the participant in acquiring and applying new knowledge and attitudes and in developing new clinical and problem-solving skills.

SITUATION RESPONSES

Situation 1 In addition to reviewing the steps in the checklist and asking for questions, the trainer should have used supporting media (slides or videotape) and then demonstrated the skill using the anatomic model. The trainer could then have asked one of the participants to repeat the demonstration. When there were no additional questions, the participants should have moved to the practice session.

Situation 2 Acknowledge that the service provider obviously has a positive attitude and strong interest in becoming a trainer. You should point out, however, that to be an effective trainer the service provider must first be a proficient service provider. After completing the clinical skills course, the service provider should work hard to become a **proficient** service provider. In addition, he will need to attend a clinical training skills course to learn to be a trainer. At that point, he will be ready to cotrain.

Situation 3 In this context, a "coach" is a proficient service provider who is training another service provider. The coach will communicate clearly, use active listening, interact and give feedback while demonstrating clinical skills, supervising practice sessions and assessing skill competency.

Situation 4 Anatomic models are used to prevent harm to clients while participants are learning new skills. In training courses using models, demonstrations or practice procedures can be stopped for discussion, several participants can practice at the same time and participants can practice their skills until they feel confident to work with clients.

Situation 5 Some trainers like to demonstrate the "wrong" way to perform a skill to make a point with their learners. The problem with this training technique is that some participants will remember the demonstration and this may affect the way they perform the skill. It is always better to demonstrate the correct way to perform a clinical skill.

SAMPLE 7-1

CLINICAL DEMONSTRATION SKILLS: SELF-ASSESSMENT GUIDE

To what degree are the following statements true of your actions or behavior when demonstrating new skills to participants?

DEMONSTRATION SKILLS	YES	SOMETIMES	NO
1. I use trainer's notes, a personalized manual or learning guide.			
2. I state the objective(s) as part of the introduction.			
3. I present an effective introduction.			
4. I arrange the demonstration area so that participants are able to see each step in the procedure clearly.			
5. I never demonstrate an incorrect procedure or short cuts.			
6. I communicate with the model or client during the demonstration of the activity/skill.			
7. I ask questions and encourage participants to ask questions.			
8. I demonstrate or simulate appropriate infection prevention practices.			
9. When using a model, I position the model as if it were an actual client.			
10. I maintain eye contact with participants as much as possible.			
11. I project my voice so that all participants can hear.			
12. I provide opportunities for the participants to practice the activity/skill under direct supervision.			

Those demonstration skills I feel competent in using include:

Those demonstration skills I would like to improve include:

SAMPLE 7-2

COACHING FOR CLINICAL SKILLS: SELF-ASSESSMENT GUIDE

COACHING SKILLS	YES	SOMETIMES	NO
BEFORE PRACTICE SESSION			
1. I greet the participant.			
2. I ask the participant to reflect on her/his performance in previous practice sessions.			
3. I ask which steps or tasks the participant would like to work on during the practice session.			
4. I review any difficult steps or tasks in the learning guide that will be practiced during the session.			
5. I work with the participant to set specific goals for the practice session.			
DURING PRACTICE SESSION			
1. I observe as the participant practices the procedure.			
2. I provide positive reinforcement and suggestions for improvement as the participant practices the procedure.			
3. I refer to the learning guide during observation.			
4. I record notes about participant performance on the learning guide during the observation.			
5. I am sensitive to the client when providing feedback to the participant during a clinical session.			
6. I provide corrective comments only when the comfort or safety of the client is in doubt.			
AFTER PRACTICE FEEDBACK SESSION			
1. I greet the participant.			
2. I ask the participant to share feelings about the practice session.			
3. I ask the participant to identify those steps performed well.			
4. I ask the participant to identify those steps where performance could be improved.			

COACHING SKILLS	YES	SOMETIMES	NO
5. I refer to my notes on the learning guide.			
6. I provide positive reinforcement regarding those steps or tasks the participant performs well.			
7. I offer specific suggestions for improvement.			
8. I work with the participant to establish goals for the next practice session.			

Those coaching skills I feel competent in using include:

Those coaching skills I would like to improve include:

EIGHT

MANAGING CLINICAL PRACTICE

INTRODUCTION

The final stage of clinical skill development involves practice of the procedure (e.g., minilaparotomy) with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, feeling and reacting human being.

The **disadvantages** of working with real clients during initial clinical skills practice are obvious. Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. Therefore, when possible and appropriate, participants should be allowed to work with clients only after they have **demonstrated skill competency** and some degree of **skill proficiency** on an anatomic model or in a simulated situation (i.e., a practice counseling session).

Planning and implementing the clinical experience cannot be done appropriately unless the trainer is well acquainted with the clinical practice sites. Visiting the practice sites before the course begins will allow the trainer to:

- develop a relationship with the clinic staff,
- find ways to overcome any inadequacies in the situation, and
- provide the best possible training experience for the participants while they are in the clinic.

Planning of the clinical experience is more fully described in **Chapter 2**. Planning includes designing a schedule that allows participants adequate time to work with clients, and developing assignments and other learning activities for participants to complete in order to provide a positive learning environment in the clinic.

Even the best planning is not always enough to ensure a successful clinical practice experience. In the classroom, the trainer is able to control the schedule and activities to a large extent. In the clinic, however, the trainer must always be alert to unplanned learning opportunities that may arise at any time, and be ready to modify the schedule accordingly. The purpose of this chapter is to prepare the trainer to manage clinical practice through monitoring and adapting to the situation in the clinic.

Chapter Objective After completing this chapter, the participant will be able to manage the clinical practice portion of a clinical skills course.

Enabling Objectives To attain the chapter objective, the participant will:

- Show respect for clients' rights during clinical training
- Identify and plan for opportunities for learning
- Consider the importance and purposes of pre- and post-clinical practice meetings
- Supervise participants during clinical practice
- Coach participants during clinical practice

CLIENTS' RIGHTS DURING CLINICAL TRAINING

Situation 1: As the clinical trainer for a minilaparotomy course, you overhear the participants, who are sitting in the clinic waiting area, discussing the cases they performed that morning. Several clients are still waiting to be seen and the housekeeping staff is tidying up the area. Clients are being mentioned by name and their behavior and cases described in detail, often in uncomplimentary terms. One participant is furious that a client refused to let him perform the procedure because he is "just learning." How would you intervene in this situation?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

The rights of clients to privacy and confidentiality should be considered at all times during a clinical training course. The following practices will help ensure that clients' rights are routinely protected during clinical training.

- The right to **bodily privacy** must be respected whenever a client is undergoing a physical examination or procedure.

- The **confidentiality** of any client information obtained during counseling, history taking, physical examinations or procedures must be strictly observed. Clients should be reassured of this confidentiality.

  Confidentiality can be difficult to maintain when specific cases are used in learning exercises such as case studies and clinical meetings. Such discussions always should take place in a private area where

other staff and clients cannot overhear and should be conducted without reference to the client by name.

- When receiving counseling, undergoing a physical examination or receiving surgical contraceptive services, **the client should be informed about the role of each person involved** (e.g., clinical trainers, individuals undergoing training, support staff, researchers).

- The **client's permission should be obtained** before having a clinician-in-training observe, assist with or perform any procedures. Understanding the right to refuse care from a clinician-in-training is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure.

- The **clinical trainer should be present during any client contact** in a training situation and the client should be made aware of the trainer's role. Furthermore, the clinical trainer should be ready to intervene if the client's safety is in jeopardy or if the client is experiencing severe discomfort.

- The **trainer must be careful how coaching and feedback are given** during practice with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

- **Clients should be chosen carefully** to ensure that they are appropriate for clinical training purposes. For example, participants should **not** practice with "difficult" clients until they are proficient in performing the procedure.

CREATING OPPORTUNITIES FOR LEARNING

Situation 2: You are the trainer for an IUD clinical skills course. Having completed the classroom portion, you are now in the clinic area supervising six participants. In the first 2 clinical days there has been an adequate number of clients to enable all participants to demonstrate competency in performing a pelvic examination. This is the third day, and according to your plan the participants should begin inserting IUDs with clients. Today, however, the weather has suddenly become cold and rainy. Only a few clients have come to the clinic and no one has chosen the IUD as her contraceptive method. What do you do with the participants now that there are no clients to be seen?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Planning for Learning

The trainer should **develop a plan for each clinic day. Samples 8-1 and 8-2** show daily plans for clinical practice for a preservice and inservice training course respectively. Having previously visited the clinic(s) and worked with the staff, the trainer will be able to design a plan that addresses each clinic's specific situation. The plan will provide a daily focus that is consistent with the learning objectives and help to ensure that all required skills will be adequately addressed. When preparing the plan, the trainer should consider the following points.

- Clinical practice should progress from **basic to more complex skills**. In an IUD clinical skills course, for example, the participants should demonstrate competency with pelvic examination skills before they perform the IUD insertion procedure with clients. Many trainers have the participants practice their counseling skills before practicing more complex method provision skills such as Norplant implant insertion. This not only ensures the safety and quality of care provided by participants but also allows them to gain self-confidence as they demonstrate competency in the basic skills.

- There may be **more participants than can be accommodated** comfortably in one area of the clinic at the same time. Generally, three or four participants are the most that a specific area of a clinic can absorb without affecting service delivery. If there are more, the trainer should plan a rotation system that allows each participant to have equal time and opportunity in each clinic area. For example, two students can be assigned to the counseling area, two to the screening area and two to the procedure rooms, with others completing special

assignments. They can change work areas every few hours, every day or every few days—whichever seems most appropriate.

It is important that the trainer share this information with the clinic staff members so they can support the participants' learning in each work area. Furthermore, the participants should understand that their gaining adequate experience to attain competency depends on their complying with the rotation schedule.

Remember: Safe and efficient provision of services must be the highest priority for everyone working in the clinic regardless of their roles and responsibilities, and must not be compromised for the sake of learning.

- Some clinic experiences, such as screening for infrequently seen precautions and managing uncommon side effects, cannot always be planned. The trainer must be alert to identify appropriate clinical situations and distribute them equally among the participants. Before each day's practice, ask the clinic staff to notify the trainer of any clients that may be of particular interest so that participants can be assigned to work with them.

- In addition to daily practice of specific clinical skills, the trainer's plan should include other areas of focus such as infection prevention, clinic logistics or client flow. Although these topics may not be directly assessed with a checklist or other competency-based assessment tool, they play an important role in the provision of high quality family planning services. To make sure that participants give adequate attention to these topics, the trainer should design and develop activities that address each one, such as:

    - Observing the infection prevention practices used throughout the clinic. Which recommended practices are being used, and which are not? Are they being used consistently and correctly? Why or why not?

    - Reviewing clinic records for the past several months to identify the types of family planning clients seen. Additional information could be obtained, such as the most common complaints, which clients return according to method used, how long clients continue using the same method, reasons for method changes, etc.

- Taking an inventory of the storeroom to identify available contraceptives, the number in stock, expiration dates, etc., as well as describing the system for procuring and storing commodities.

- Drawing a map of the clinic and marking client flow through the clinic. The time spent at each "point" in the clinic (reception, history taking, physical exam, etc.) could also be noted.

These activities can be used as the basis for discussions to improve the participants' understanding of the issues involved in the provision of high quality services. Recommendations for improving the services provided in the clinic can be developed and given to the clinic staff if appropriate.

- Inevitably there will be times when there are few or no clients in the clinic. The trainer should have ready additional activities, such as those described above, for the participants. Case studies and role plays also are very useful at such times. Even without clients, learning must continue. Taking extended breaks or leaving the clinic site early are not acceptable options.

In the Clinic

Situation 3: It is the second day of clinical practice in a Norplant implants clinical skills course. The four participants whom you are supervising have many questions about how to manage the side effects of Norplant implants, but no clients with problems have come into the clinic. You and the participants are about to have an extended post-clinical practice meeting about recommended infection prevention practices as observed in the clinic. At this time, a client arrives complaining of heavy prolonged vaginal bleeding since her implants were inserted 6 months ago. You had planned on discussing this and other side effects and their management at tomorrow's post-clinical meeting. What do you, as the trainer, do in this situation?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

As has been mentioned, planning alone is not sufficient to guarantee a successful clinical practice. There are several key strategies that a clinical trainer can use in the clinic to increase the likelihood of success.

- The trainer must actively monitor the skills each participant is able to practice, and with what frequency, so that each participant has adequate opportunities to develop competency. A participant who demonstrates competency in no-scalpel vasectomy (NSV), for example, should not be assigned additional NSV clients until all the

other participants also have achieved competency. Only then can competent participants be given additional opportunities to perform NSV and move towards proficiency.

Remember: The goal of mastery learning is that every participant achieve competency by the end of the course. The trainer is responsible for meeting this goal.

- It is essential that the trainer be flexible and constantly alert to learning opportunities as they arise in the clinic. This requires knowing about the clinic—how it is set up and functions, the client population, etc.—as well as having a good working relationship with the staff. The trainer will need to rely on the staff's cooperation in notifying her/him of unique or unusual clients and allowing participants to provide services to these clients. This relationship is most easily established during the precourse visit(s) made by the trainer.

- The participants also should be encouraged to watch for such learning opportunities in the clinic. The trainer may then decide which of the participants, and how many, will be assigned to a particular client. The trainer and participants should remember that clinical experiences need to be shared equally. Therefore, the participant who identifies a case may not be assigned to it if this participant has had a similar case before. It is not appropriate to subject the client to a procedure (e.g., pelvic examination) multiple times simply so that all participants can practice a skill.

- To take advantage of opportunities as they occur may require that the trainer modify the plan for that day and subsequent days, but with as little disruption as possible to the logical flow of activities. Participants should be notified of any changes as soon as possible so that they can be well prepared for each clinical day.

- Rarely will all participants have the opportunity to work with all types of clients. The clinical trainer will need to supplement, with case studies and role plays, the work done with clients (see **Chapter 5**). The trainer should identify important but uncommon experiences and prepare activities in advance. Actual cases seen in the clinic may also serve as the basis for such activities. These can then be used during clinical sessions to expand the participants' range of experiences.

PRE- AND POST-CLINICAL PRACTICE MEETINGS

Pre-Clinical Practice Meetings

The trainer and participants should meet at the beginning of each clinical practice session. Most clinical sessions occur in the morning because this is when the client caseload is heaviest. The meeting should be scheduled early enough so that participants will be ready to attend to clients by the normal opening time. It is not appropriate to expect the clinic staff to make clients wait until the participants are available, because this may cause excessive delays to both clients and staff.

The meeting should be brief. Items to be covered include:

- the learning objectives for that day
- any scheduling changes that may be needed
- participants' roles and responsibilities for that day, including the work assignments and rotation schedule if applicable
- special assignments to be completed that day
- the topic for the post-clinical practice meeting, so that the participants can take special note of anything happening during the day that would contribute to the discussion
- questions related to that day's activities or from previous days if they can be answered concisely; if not, they should be deferred until the post-clinical practice meeting

Post-Clinical Practice Meetings

The clinical trainer should end each clinical day with a meeting to review the day's events and build on them as learning experiences. A minimum of 1 hour will be needed. These meetings are used to:

- review the day's learning objectives and assess progress toward their completion
- present cases seen that day, particularly those that were interesting, unusual or difficult
- respond to clinical questions concerning situations and clients in the clinic or information in the reference manual
- plan for the next clinical session, making changes in the schedule as necessary

- conduct additional practice with models if needed

- review and discuss case studies, role plays or assignments that have been prepared in advance by the participants. These activities should complement the sessions conducted during the classroom portion of the course, especially when classroom time is limited and clinical experience is necessary to gain a better understanding of the issues to be discussed. Topics for case studies, role plays and assignments include:

  - side effects and their management
  - quality of care
  - provision of services—logistics, infection prevention
  - medical barriers to providing high quality services

These meetings, especially extended sessions, should be conducted away from the client care area if possible. Although every clinic will not have a meeting room, an effort should be made to locate a space that will allow free discussion, small group work and practice on models and that will not interfere with efficient client care or other staff duties. The trainer may need to be very creative to find such a location. If weather permits, these sessions can be held outdoors. They can also be held at the classroom if it is nearby, although the trainer and participants may spend valuable time getting there.

THE TRAINER AS SUPERVISOR

Situation 4: You are conducting a course on reversible methods that has now moved into the clinical area. It is the first day in the clinic and the seven participants you are supervising are eager to begin working with clients as quickly as possible. You are going to supervise their interactions with clients and their service provision skills. After a short period of calm, you suddenly have four participants who need you to assist them at the same time: one is going to do basic counseling, another needs to give a Depo-Provera injection, another needs to perform a pelvic examination and the fourth needs to help a client who has returned complaining of nausea, breast tenderness and spotting between periods since beginning combined oral contraceptives 2 months ago. What do you do?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

In the role of supervisor, the trainer must monitor participant activities in the clinic so that:

- each participant receives appropriate and adequate opportunities for skill practice,

- participants do not disrupt the efficient provision of services within the clinic or interfere with staff and their duties, and

- the care provided by each participant does not harm clients or place them in an unsafe situation.

The trainer must always be with participants when they are working with clients, especially when they are conducting initial counseling sessions and performing clinical procedures. Participants, in their eagerness to learn a new skill, often present certain methods in a persuasive manner while counseling a client—if the client chooses the IUD, the participant will have the opportunity to perform IUD insertion. The trainer must monitor the counseling session to be sure that information on all contraceptive methods is presented in an unbiased manner and that client screening is performed to prevent unnecessary examinations or provision of an unsuitable method. Once the trainer is comfortable with the counseling skills of the participants, the trainer may allow them to be more independent.

Most trainers have more than one or two participants to supervise. Because the trainer cannot be with all of them at the same time, other methods of supervision must be used.

- Participants must understand what they can do independently and what requires trainer supervision, so that they can keep busy when the trainer is involved with another participant. Participants should be made responsible for ensuring that they are supervised when necessary. The trainer, however, still holds the ultimate responsibility.

- Additional activities that require no direct supervision will give participants the opportunity to be actively engaged in learning when they are not with clients.

- Clinic staff also can act as supervisors if the trainer is confident of their clinical skills and ability to provide appropriate feedback. The possibility of having clinic staff supervise participants is another reason why the trainer should get to know the staff before the training begins. During the initial visit to the clinic, the trainer can observe the

skills of the staff members, and verify that they are competent, if not proficient, service providers. The trainer may also have the opportunity to assess their coaching skills. There may even be time to work with staff members to improve their skills so that they can serve as role models and support participant learning.

The more participants there are in the clinic, the more the trainer relies upon the staff also to act as trainers. Nevertheless, the ultimate responsibility for each participant, including that of final assessment of skill competency, is the trainer's. For this reason, if multiple clinical sites are used during a course, a trainer must be assigned to each site.

- Because clinic staff usually are not involved in the classroom portion of a course, they do not have an opportunity to get to know the participants and their abilities before they arrive at the clinic. Therefore, it is a good idea to share such information with the clinic staff whenever they will have to take over a large part of the participant supervision. Clinic staff should also be encouraged to do an initial assessment of participants' skills before allowing them to work with clients so that they can feel confident that the participants are well prepared.

- Clinic staff should also be aware of the feedback the trainer would like to receive from them about participants.

    - Will it be oral, written or both? If written feedback is needed, the trainer should design an instrument or form to guide the clinic staff. The trainer should furnish a sufficient number of copies of the form and instruct the staff in its use. **Samples 8-3 and 8-4** are clinical practice feedback forms for preservice and inservice training respectively. The trainer should develop a form that staff members can complete quickly and easily.

    - How frequently will feedback be provided? Daily? Weekly? Only at the end of training?

    - Should both positive and corrective feedback be provided?

    - Are there appropriate administrative channels through which the feedback should be transmitted? In some clinics, for example, staff members provide their feedback to the individual in charge of the clinic who then prepares a report for the trainer.

- When designing the feedback system, the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinic staff, who already have a very busy schedule. It is best to keep the system as simple and easy to use as possible.

THE TRAINER AS COACH

Situation 5: You are coaching a participant who is inserting an IUD with a client. The client is aware that the "service provider" is learning a new skill and she appears somewhat nervous, but has agreed to have the insertion done by the participant. The participant performs the first steps of the insertion procedure correctly, but has some difficulty applying the tenaculum to the cervix. What would you do? How would you interact with her?

What would you do if the participant, after inserting the speculum, forgot to swab the cervix before continuing with the procedure?

What would you do if the participant had difficulty using the withdrawal technique for IUD insertion and began pushing the IUD inserter tube to release the IUD in the uterus?

Write your responses on a piece of paper and then compare your responses with the ones found at the end of this chapter.

One of the most difficult tasks for the trainer, and one with which even experienced trainers struggle, is to be a good coach and provide feedback in the clinic setting. No matter how comfortable a trainer may be in giving feedback in the classroom or while working with models, the situation changes in the clinic. The clients, staff and other participants are nearby and the clinic services need to keep flowing smoothly and efficiently. The trainer often feels pressured to keep things moving because the client does not want to wait a long time for services and the trainer needs to be available to all the participants. Spending "too much time" with any one client or participant has an impact on everyone.

Feedback Sessions

The feedback sessions before and after practice are often skipped in an effort to save time. These sessions, however, are very important for the continued development of the participant's skills. Without adequate feedback and coaching, the participant may take longer to achieve competency, and end up using the "saved" time later. Keep in mind that by this time the participant has already demonstrated competency on a model and should not need extensive feedback. To minimize disruption of

services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.

The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is for a participant's performance with models or with clients.

- The participant should first identify personal strengths and the areas where improvement is needed.

- Next, the trainer should provide specific, descriptive feedback that includes suggestions of not only what, but how, to improve.

- Finally, the participant and the trainer should agree on what will be the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the trainer places a hand on the participant's shoulder, it is a signal to stop and wait for further instructions.

The feedback session before practice should be given before entering the room to work with the client. The feedback session after practice can be delayed until the client's care has been completed and the client is ready to leave the clinic. The trainer should try not to delay it much longer than this (e.g., until the end of the day). Feedback is always more effective when given as soon after the procedure as possible. Giving it soon after the procedure will also allow the participant to use the feedback with the next client for whom services are provided, if appropriate.

Feedback During the Procedure

Be sure the client knows that the participant, although already a service provider, is also a learner. Reassure the client that the participant has had extensive practice and mastered the skill on models. The client should expect to hear the trainer talk to the participant, for example, encouraging

the participant to "tent" the skin further during Norplant implants insertion, and that it does not mean that something is wrong. Finally, the client should clearly understand that the trainer is a proficient service provider and is there to ensure that the procedure is completed safely and without delay.

Positive Feedback

Positive feedback is often easy to give and can be provided in the presence of the client. Trainers often think that hearing feedback, even positive

feedback, will disturb the client. Many clients, however, find it comforting to hear the service provider being given positive feedback.

- Keep the feedback restrained and low-key; overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, "What is being hidden?" "Why is it so surprising that this person is doing a good job?"

- Positive feedback can be conveyed by facial expression and tone of voice rather than words, and still be highly effective.

At the same time, the **absence** of feedback of any kind can be disturbing to the participant. By this phase of skill development the participant is expected to do a good job even with the first client, and is accustomed to hearing positive comments. Therefore, in order to maintain the participant's confidence, it is still important to give positive feedback.

Corrective Feedback

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback low-key and restrained. There are a number of techniques that will make it easier.

- Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.

- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner, for example, "You might find it easier to manipulate the tenaculum if you use your middle finger and thumb, rather than your first finger and thumb." Do not go into lengthy explanations of why you are making the suggestion or offering an observation—save that for the post-practice feedback session.

- To help a participant avoid making a mistake, the trainer can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the participant to name the next step **before** doing anything further could help avoid an error. This is **not** the time to ask hypothetical questions about potential side effects and complications, as this may distract the participant and alarm the client.

- Sometimes, even though they have had extensive practice on models, participants make mistakes that can potentially harm the client. In

these instances, the trainer must be prepared to step in and take over the procedure at a moment's notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.

The best approach to providing corrective feedback is to minimize, or even eliminate, the need for it by conducting effective practice sessions in the classroom. If participants become truly competent on models, there will not be much need for corrective feedback in the clinic except in unusual situations.

SUMMARY

During the clinical practice, the trainer is responsible for ensuring that all participants have adequate opportunities for practicing with clients so that by the end of the clinical experience they are competent in the required skills. The trainer must prepare for the clinical practice by becoming familiar with the clinic site and the staff who work there, and by developing a logical plan for skill practice and activities to complement and support those skills. This includes being prepared with activities that will fill gaps between clinical experiences and keep the participants continually involved in learning activities. Most important, the trainer must be constantly alert to what is going on in the clinic in order to identify potential learning opportunities, even when they are not consistent with what was planned for that day. The trainer must supervise all activities performed by the participants or delegate some of the responsibilities to clinic staff. And finally, the trainer must continue to provide both positive and corrective feedback to participants in the clinic to ensure the continued development of skills.

SITUATION RESPONSES

Situation 1 It is important that you step in and stop the conversation right away in a low-key manner. Suggest that you all move to a more private location. Once there, ask the participants why they think you had them move and then discuss the importance of confidentiality and privacy as essential elements of clients' rights and quality care. The participant's anger at being "rejected" by the client should also be explored. Emphasize that this too is a key part of clients' rights and should not be taken personally; perhaps that client has had a bad experience with a "new learner" in the past.

Situation 2 Prior preparation is vital at a time like this. You should already have prepared a number of activities, including case studies, role plays and other assignments that can be used when there are no clients. You should then gather the participants in a place where they will not interfere with clinic routines and get them started on an activity. If you have nothing prepared, you will need to come up with something QUICKLY! Participants must not stand around doing nothing, nor should they go home early because you, the trainer, are unprepared. Situations like this occur in almost every clinical practice, so it is very important that you think ahead and are ready with alternative activities. Once you have them ready, you can use them again and again with different groups of participants.

Situation 3 Now is **not** the time to keep to the planned schedule! Not only is the management of Norplant implants side effects of interest to the participants, it is uncommon to see these clients in the clinic. You should take advantage of this opportunity to have participants work with this client. It probably will not be possible for all four participants to interact with her, because you risk overwhelming her. You will have to decide which two participants will have this experience. You should note who had this practice, so that the next time such a client comes in, different participants can be given the opportunity to work with her. You should supervise the client-participant interaction. Afterwards, during the post-clinical meeting, the two participants should share their experience with the others, and discuss alternative ways of helping this client. It is probably a good idea to have the more detailed discussion of side effects and their management that is planned for the next day. The infection prevention discussion can be postponed until tomorrow.

Situation 4 Obviously, you cannot be in four places at one time. One option is to ask staff members to supervise three of the participants while you supervise

one. To feel comfortable doing this you will need to know the skills and abilities of the staff, which can only come through working and communicating with them before such a situation arises. Based on your assessment of their skills, you can decide which participant you will supervise. For example, you may want to supervise the participant performing the pelvic exam as that is a more advanced skill, especially if you have doubts about the staff's skills in this area. Or you may want to accompany the participant who will deal with side effects of combined oral contraceptives, if that is a new topic or one with which participants have had difficulty.

If you cannot use the staff to supervise some of the participants, you have a long and very busy clinical practice period ahead of you! You need to set priorities for the types of skills that need supervision. If participants have had considerable practice in one or two of the areas in question, those areas are not top priorities. The staff may need to go ahead and deal with those clients to avoid having them wait for a long period while you supervise other participants and clients. You could also set priorities by how long the activity will take. The Depo-Provera injection, for example, should only take a few minutes to give, so you could supervise that first and then move on to other participants. You will constantly be struggling throughout the clinical practice with this problem, however, if you cannot rely on the staff members to help supervise clients. It is worth investing some time to get to know them and their skills, and even help them improve, in order to have some help in the clinic.

Situation 5 You should let the participant know what she is doing well while she is performing the procedure. A few brief comments such as "nice job," or "well done," said in a moderate tone are adequate. This is not necessary for every step in the procedure, but enough to let the participant know that she is doing well. When the participant gets to a step where there is a problem, such as in this case of applying the tenaculum to the cervix, you may want to make a few calm, supportive statements indicating how to overcome the difficulty. Some examples include: "Try holding the tenaculum with your thumb and middle finger," or "Turn the tenaculum over; that may make it easier." Again, these should be said in a calm, straightforward manner. Do not let the participant struggle for very long before you offer advice. If she continues to have trouble, be prepared to step in and take over. Although this is not a life-threatening step for the client, it is uncomfortable, and you do not want to prolong the procedure. After the insertion is complete and the client is on her way out of the clinic, find a quiet place to spend a few minutes providing feedback to the participant, including more detailed information on what her problems were and ways to overcome them.

If the step is an important one, as in the second example (forgetting to swab the cervix), as soon as you realize that the participant is about to make an error, you need to intervene. In this case, as soon as it is clear that the participant is going to apply the tenaculum without cleaning the cervix, you might ask her to wait and consider the next step carefully. A hand on the shoulder may also convey the message to stop, and think before proceeding. If the participant is unable to identify that she is skipping a step, tell her what to do. Again, this should be done in a calm, direct manner in such a way that it does not prolong the procedure.

The third example, pushing the IUD inserter tube into the uterus, is a potentially dangerous or even life-threatening mistake. Use the same approach as above—stopping the participant, having her think for a minute, and so on—but if she is not able to identify the problem and correct it, you **must** step in and finish the procedure to ensure the client's safety.

SAMPLE 8-1

PRESERVICE DAILY PLAN FOR CLINICAL PRACTICE

Date: 07 March 1998

Clinical Site: University Hospital Family Planning Clinic

Tutor: Mary Smith

Clinical Instructor/Preceptor(s): Margaret Jones

Learning Objectives:

- To observe a clinical instructor/preceptor providing Depo-Provera injections to clients (include observation of appropriate infection prevention techniques)
- To practice counseling clients interested in temporary family planning methods under the supervision of a clinical instructor/preceptor
- To practice, and assess as appropriate, pelvic examination skills with clients, under the supervision of a clinical instructor/preceptor
- To practice IUD insertion on the pelvic model
- To develop skills in the management of Depo-Provera side effects by observing a clinical instructor/preceptor while working with clients and through case studies

Activities:

- Preclinical meeting: 30 minutes
    - Review learning objectives for the day.
    - Give student assignments for clinical areas—two students in the counseling area, two in the examination room, and two in the injection room—and remind students that they will rotate every hour.
    - Encourage students to practice IUD insertion on the pelvic model if there are no clients available in their area.
    - Distribute case studies to be discussed in the postclinical meeting that can be read and prepared if there are no clients available.
- Clinical activities: 4 hours
- Postclinical meeting: 1½ hours
    - Ask each student to present for discussion one client with whom s/he worked that day.
    - Divide students into pairs and have them work through the first case study and then report their conclusion for discussion. Do the second case study if time permits.
    - Review plan for the next clinical session.

SAMPLE 8-2

INSERVICE DAILY PLAN FOR CLINICAL PRACTICE

Date: 07 September 1998

Clinical Site: Teaching Hospital Family Planning Clinic

Clinical Trainer: Swaraj Shresta

Clinical Instructor/Preceptor(s): Chandra Shah

Course: IUD Insertion and Removal

Learning Objectives:

- To practice counseling clients interested in using the IUD as their family planning method under the supervision of the clinical trainer or clinical instructor/preceptor
- To practice, and assess as appropriate, pelvic examination skills with clients, under the supervision of the clinical trainer or clinical instructor/preceptor
- To practice IUD insertion on the pelvic model
- To observe and assess the infection prevention practices used by clinic personnel

Activities:

- Preclinical meeting: 30 minutes
    - Review learning objectives for the day.
    - Give participant assignments for clinical areas—two participants in the counseling area, two in the examination room, and two observing infection prevention practices—and remind them that they will rotate every 2 hours.
    - Encourage participants to practice IUD insertion on the pelvic model if there are no clients available in their area or they complete their observations.
    - Distribute the infection prevention observation guide and briefly review how it is used.
- Clinical activities: 4 hours
- Postclinical meeting: 1½ hours
    - Ask each participant to present for discussion one client with whom s/he worked that day.
    - Have each pair of participants share the infection prevention practices that they observed and assess how they compare with what they have been taught in the course. Identify possible barriers or reasons for incorrect practices. Discuss ways to improve the IP practices in the clinic.
    - Review plan for the next clinical session.

SAMPLE 8-3

FINAL PRESERVICE CLINICAL PRACTICE FEEDBACK FORM

Dates:		**Clinical Site**:	
Student:		**School**:	
Tutor:		**Clinical Instructor/ Preceptors(s)**:	

Please rate this student in the following areas using the rating scale below. Add any additional comments you feel will contribute to the assessment of this student.

5-Strongly Agree **4-Agree** **3-No Opinion** **2-Disagree** **1-Strongly Disagree**

AREA OF ASSESSMENT	RATING
1. The student attended all clinical practice sessions.	
2. The student was on time for each session and remained for the entire scheduled time.	
3. The student entered the clinical practice with adequate knowledge of family planning.	
4. The student entered the clinical practice with competency on models or in role plays in key clinical skills (see list below).	
5. The student was aware of the learning objectives and actively looked for learning opportunities to meet them.	
6. The student recognized personal limitations and sought help/additional practice when needed.	
7. The student was respectful towards the clients and respected their privacy and the confidentiality of information about them.	
8. The student contributed to the efficient and safe provision of family planning services during clinical practice sessions.	

Please attach copies of the skills checklists that you used to assess this student's competency with clients in each of the following areas:

- Initial counseling for a new family planner acceptor
- Method-specific counseling for the chosen method, including provision of that method using recommended infection prevention practices
- Client screening and assessment
- Pelvic examination, including infection prevention practices
- IUD insertion, including infection prevention practices

What are the areas in which the student **did not** achieve competency or in which you feel additional practice is required? Please list these on the back of this form. For each, please indicate what and how much additional work you feel would be needed for the student to demonstrate competency.

SAMPLE 8-4

FINAL INSERVICE CLINICAL PRACTICE FEEDBACK FORM

Dates:		**Clinical Site**:	
Participant:		**Course**:	No-Scalpel Vasectomy (NSV)
Clinical Trainer:		**Clinical Instructor/ Preceptors(s)**:	

Please rate this participant in the following areas using the rating scale below. Add any additional comments you feel will contribute to the assessment of this participant.

5-Strongly Agree **4-Agree** **3-No Opinion** **2-Disagree** **1-Strongly Disagree**

AREA OF ASSESSMENT	RATING
1. The participant attended all clinical practice sessions.	
2. The participant was on time for each session and remained for the entire scheduled time.	
3. The participant entered the clinical practice with adequate knowledge of NSV.	
4. The participant entered the clinical practice with competency on models for NSV and in role plays for counseling for NSV.	
5. The participant was aware of the learning objectives and actively looked for learning opportunities to meet them.	
6. The participant recognized personal limitations and sought help/additional practice when needed.	
7. The participant was respectful towards the clients and respected their privacy and the confidentiality of information about them.	
8. The participant contributed to the efficient and safe provision of family planning services, especially NSV, during clinical practice sessions.	

Please attach copies of the skills checklists that you used to assess this participant's competency with clients in each of the following areas:

- Method-specific counseling for NSV
- Client screening and assessment for NSV
- NSV, including infection prevention practices

What are the areas in which the participant **did not** achieve competency or in which you feel additional practice is required? Please list these on the back of this form. For each, please indicate what and how much additional work you feel would be needed for the participant to demonstrate competency.

NINE

CONDUCTING A CLINICAL TRAINING COURSE

INTRODUCTION

The clinical trainer is both the content and skills expert in a clinical skills training course. The course outline provides a foundation for the planned training; however, it is the clinical trainer who is responsible for turning the training plan into a successful training course. The clinical trainer must plan how to deliver the content creatively, in a way that keeps the training focused on the participants and ensures that the learning objectives are achieved. Effective organization of the logistical support for the course, as described in **Chapter 2**, must occur before the trainer begins to conduct the course.

The key steps in conducting a clinical skills course are described briefly in this chapter. They are drawn from the training techniques presented in previous chapters and provide the framework for organizing each part of the course.

Chapter Objective

After completing this chapter, the participant will be able to describe how to prepare for and conduct an effective clinical skills training course.

Enabling Objectives

To attain the chapter objective, the participant will:

- Prepare for training
- Present a course overview
- Conduct training sessions
- Use competency-based knowledge and skill assessments
- Determine whether a participant is qualified based on observed and measured performance
- Evaluate a clinical training course
- Provide help and followup after training

PREPARING FOR TRAINING

Situation 1: You are observing a colleague as she conducts her first service provider course. She asks many questions and interacts with the participants, but she has a tendency to stand behind a table and read information from the reference manual. What would you advise her to do to prevent reading from the reference manual?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Trainer preparation is essential to conducting a successful course. The trainer will find that the thorough preparation was well worth the effort when the course runs smoothly and the participants leave with the ability to competently perform the skills acquired during training. A well-designed learning package contains three planning documents the trainer will use in preparing for training—the **course syllabus, schedule** and **outline**. As described in **Chapter 2**, these components of the learning package may need to be revised to reflect adaptations to the course. This chapter assumes that the material made available to the trainer reflects such changes.

Preparation for training falls into two categories: getting ready for the course in general (e.g., obtaining necessary supplies and equipment) and planning individual training sessions. The following steps are recommended.[1]

Overall Preparation

- **Review the course syllabus**, including the course description, goals, learning methods, training materials, methods of evaluation, course duration and suggested course composition (see **Sample 2-3**).

- **Review the course schedule** (see **Sample 9-1**).

- **Study the course outline** (see **Sample 9-2**). The course outline provides detailed suggestions regarding the teaching of each objective and the facilitation of each activity. Based on suggestions in the course outline and the trainer's own ideas, the trainer will gather the necessary equipment, supplies and materials. The trainer should also compare time estimates in the course outline to the schedule to ensure that sufficient time has been allotted for all sessions and activities.

[1] Even if the clinical trainer is presenting only a portion of the course, the trainer should be familiar with the entire course design, goals and content, and should review the course syllabus, schedule, outline and reference manual.

- **Read and study the reference manual** to ensure complete familiarity with the content to be presented during the course.

- **Review the pre- and midcourse questionnaires** and make copies of the questionnaires, matrix and answer sheets if needed.

- **Check all audiovisual equipment** (e.g., overhead projector, video player, flipchart stand).

- **Check all anatomic models** (e.g., are they clean and in good condition, are all parts in place).

- **Practice all clinical procedures** using the anatomic model(s) and the learning guides and checklists found in the trainer's notebook and participant's handbook.

- **Obtain information about the participants who will be attending the course.** It is important for the clinical trainer to know basic information about participants such as:

    - **Why the participants enrolled** in the course. Sometimes this can be determined in advance, although often the clinical trainer has to ask participants on the first day of training. It is important for the trainer to know why they are attending and how they feel about coming to the course in order to create a positive learning climate and achieve course objectives.

    - The **experience and educational background** of the participants. The clinical trainer should attempt to gather as much information about participants as possible before training. If this is not possible, the trainer should inquire about their backgrounds and expectations during the first day of the course.

    - The types of **clinical activities** the participants will perform in their daily work after training. Knowing the exact nature of the work that participants will perform after training is critical for the clinical trainer. The trainer must use appropriate, job-specific examples throughout the course so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.

PRESENTING A COURSE OVERVIEW

Situation 2: You have been waiting to attend this Norplant implants training course for over a month. Now the day is here and you are sitting in the room with 14 other participants. The two trainers are ready to begin the course. What information are you hoping will be covered during the course overview?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

The day has finally arrived! The classroom has been arranged and the participants are entering the room and taking their seats. Although you feel a little nervous, you know that you have plans for beginning the course on a positive note. These plans include an interesting and exciting course overview.

Course Overview

An introductory **course overview** may be used to:

- Review course goals and participant learning objectives

  Examples:

  "Welcome to the clinical training skills course. My name is Ilka and I will be one of your trainers. The goal of this course is to prepare proficient service providers to become clinical trainers. As clinical trainers, you will be training new service providers. Let's take a look at the course objectives."

  "Hello, my name is James and I am your cotrainer. There are a number of objectives that you will need to achieve to become a clinical trainer. These objectives are listed in the course syllabus in your participant's handbook and are shown on the flipchart. By the end of this course, you will be able to...."

- Allow participants to become acquainted with one another

  Example:

  "Let's take a few minutes and introduce ourselves. I would like you to find another participant to interview. In addition to your partner's name, ask her or him to share one characteristic of an effective trainer. Please take about 5 minutes and then we will meet everyone."

- Describe the course schedule and activities that will occur during the course

  Example:

  "Each of you has a copy of the course schedule. Note that the major activities are identified for each day including classroom presentations, clinical demonstrations using the models and practice sessions. You will see that during this course you will have the opportunity to plan and present a classroom presentation and a clinical role play. Are there any questions about the schedule?"

- Examine the course materials

  Example:

  "The reference manual we will be using in this course is *IUD Guidelines for Family Planning Service Programs*. The manual contains the essential, need-to-know information we will be learning during the course. In addition, you have a copy of the participant's handbook which contains the course syllabus, schedule and other information we will use during the course."

- Review participant expectations for the course

  Examples:

  "Each of you came to this course with certain expectations. Now that you are aware of the course goals, objectives and schedule, the trainers would like to know if you have any special expectations. These could be things you want to learn or do during the course in addition to what has been planned."

  "Please talk with the person next to you. Once you have identified your expectations, please write them on the flipchart in the front of the room. These will be posted on the wall for reference throughout the course."

- Indicate the location of telephones and other services

- Answer any questions participants might have

CONDUCTING A TRAINING SESSION

Situation 3: You are conducting a clinical skills course for IUD service providers. During the session on counseling, you suddenly decide this would be a good time for an activity. You ask the participants to divide into small groups and practice counseling each other. As you move around the room you find that most of the participants in the small groups are just talking and that they are not sure what they are supposed to do. You ask yourself, what went wrong?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

A training session is a block of time allocated for a specific learning objective. There may be several types of learning activities (e.g., illustrated lecture, demonstration, role play) within a session; selecting appropriate activities is described in more detail later in this section. The course schedule shows the specific sessions to be conducted each morning and afternoon during the course. The course outline breaks down each session by its objectives and suggests learning activities and methods for each one. The clinical trainer may need to modify session activities to meet the needs of the participants. To conduct a training session successfully, the clinical trainer should consider the needs of the participants (e.g., changes resulting from participant expectations or results of the precourse questionnaire), review the suggestions in the course outline and then plan the session. This will involve reviewing the objectives and learning activities, planning warmup activities and considering all aspects of conducting the session.

Objectives

Objectives, which can be found in the course outline, should be clearly stated for each course session. A learning objective is defined as a statement of what the participant will know or be able to do after completion of a section of training. Before each session begins, write the objective on the flipchart, the writing board or a transparency. Place the written objective in a visible place for all to see during the training session.

Learning Activities

Learning activities support participants in attaining the learning objectives. The goal is to keep the participants interested, active and involved. The enthusiasm of the clinical trainer has a direct impact on the participants' ability to maintain an interest in the activities. If the clinical trainer has high expectations of success, the participants will follow.

The learning activities recommended in the course outline include activities that:

- Allow participants **to get to know each other**
- Produce or heighten **energy in the group**
- Influence how participants **think about certain issues**
- Provide the opportunity to **learn and practice a particular skill**

Warmup activities encourage participant involvement and interaction and can be helpful in diminishing any personal concerns the participants may have. Start each day with a warmup activity to **bring the group together** and begin work with a positive, energetic attitude. Warmups provide the group an opportunity to learn something in a nontraditional way and usually help the group to get to know one another better. **Clinical trainers should participate in these activities.** Below are some examples of warmup activities:

- Everyone should get acquainted on the first day of training. Even when the participants already know each other, the clinical trainer must get to know them. Instead of using the "tell us your name" option, the trainer can divide the group into pairs and give participants a few minutes to interview each other. The participants then have a minute to introduce their partners by name and to share at least two unique characteristics about them.

- The trainer divides the group into pairs and ask participants to tell each other their favorite food or name the animal they feel best describes them and why. This information is shared with the group when participants introduce their partners.

- The trainer gives the participants slips of paper, and ask them to write down at least three things they would like to learn during that day's activities. They attach their slips to a poster board or piece of flipchart paper, which is posted in the classroom. The clinical trainer can then review these expectations with the group and tell them which topics will and will not be covered. This activity can also help the clinical trainer focus the course on individual or group learning needs and interests.

- Participants and the clinical trainer form a circle and toss a soft ball around the circle. Participants state their names as they catch the ball. After a few minutes, when they catch the ball, they call out the name of the person who tossed it to them.

This activity can also be used throughout the course by substituting a quick information exchange for people's names. For example, the clinical trainer may ask, "What are the indications for IUD use?" The ball is tossed around the circle and participants call out a different indication as they catch the ball.

- Participants write down three questions and find someone in the room they do not know well. Each participant then asks questions of the other. The participants then introduce their partners to the group by sharing both the questions and the answers.

- The trainer prepares a name tag for each participant and places the tags in a box. Each participant draws a name tag. Participants locate the person whose name tag they drew and introduce themselves. (This is especially useful for larger groups—20 or more.)

Activities to **produce or heighten energy** are useful during the day (especially after lunch) when the trainer notices that the group's energy is fading and the participants need a boost. An energizer can take from 5 to 20 minutes. It can be as simple as "let's stand and stretch." The purpose is to divert attention away from the topic at hand to give the mind and body a rest by using them differently. Several short energizers can be found in **Appendix B**.

Activities designed to **influence attitudes**, however, are more complex and usually take more time. Role plays, case studies and coaching are examples of such activities and are fully described in **Chapters 5 and 7**.

Informal Learning Activities

Activities outside of class and conversations during meals and refreshment breaks can be a means of informal learning for both the clinical trainer and the participant, as well as a means of creating a relaxed atmosphere. The clinical trainer must remember, however, to maintain professional standards and respect the confidentiality of such informal conversations. Gossip about participants and other clinical trainers is rarely, if ever, helpful. Participants may attempt to gain the favor of trainers by being critical of their peers. It is important to defend the dignity of the training course and the participants by not being drawn into such interactions.

Commitments made by a clinical trainer during informal activities are as valid as those made in the classroom. The trainer should follow through on promises made to participants, whether it is for photocopying a topic-related article, arranging an introduction to a colleague or bringing up a participant's point for discussion in the next training session.

Incorporating into the learning activities ideas that participants discussed during informal conversations is a way for the clinical trainer to show that their contributions are valued. The trainer can ask participants to help with remembering certain topics: "Please remind me to use your experience with a difficult removal of Norplant implants in tomorrow's demonstration."

Clinical Practice Sessions

The steps in **learning and practicing a clinical skill** are detailed in **Chapter 7**. Providing participants with meaningful classroom and clinical practice sessions is critical to the success of any clinical training course. In preparing and conducting these sessions, the clinical trainer relies heavily on clinical skills learning guides (see **Chapter 6**).

During the clinical practice sessions, the clinical trainer is responsible for the participants, and should observe and interact with them at all times. The trainer should be prepared to suggest alternative activities or exercises if the client caseload is low during a particular clinical session.

In addition to the clinical skill or activity, there are other skills that participants are expected to learn. These include building a relationship with the client, listening attentively to the client's reproductive goals and providing information that is clear, simple and direct. These skills may be unfamiliar or deemed unimportant by some participants. Under these circumstances, the clinical trainer will need to design activities which provide a low-risk opportunity to explore new behaviors and help change these attitudes. For example, conducting a counseling role play after which the participants receive constructive feedback may be an effective way to highlight areas needing improvement.

Instructions for Participants

Writing instructions for an activity, particularly if there are multiple steps or parts, is important to the activity's success. The process of writing clear instructions helps the trainer to think through each part of the activity with the participants in mind. It also results in more realistic timing of each activity.

Instructions can be presented orally, but also should be presented in writing, using paper (handout), the writing board, the flipchart or an overhead projector, so that participants can refer to them during the activity. Written instructions provide clarity for everyone; without them, confusion and chaos can result.

Materials and Equipment for Learning Activities

The materials needed to support a learning activity usually are suggested in the course outline. The clinical trainer is responsible for ensuring their availability and organizing them before the training session. In particular, the trainer should review:

- The chapters (or pages) in the reference manual that will be referred to during the activity
- Any supplemental written materials needed for the activity (e.g., a role play or case study)
- Supplies and equipment needed (e.g., anatomic models, IUDs, complete sets of surgical instruments, bleach and buckets, paper and pencils)
- Room arrangements (e.g., chairs and tables arranged in a certain configuration)

Introductions

The introduction of each training session in the course sets the tone and atmosphere for that session. **Chapter 3** provides several specific examples for introducing a training session. The clinical trainer should choose a technique with which s/he is comfortable. As the clinical trainer gains more experience in interactive training methods, the variety of introductions used will increase. The important point to remember is that the trainer's enthusiasm and interest in the topic should be genuine. The participants will recognize if they are not and, as a consequence, the momentum the clinical trainer intends to build will be reduced.

During the introduction, the clinical trainer should monitor and assess the group's attentiveness. When the group is focused totally on what is unfolding before them, they will be ready to move to the next part of the session.

Questions

After a learning activity is completed, the participants need time to integrate what they have just experienced with what they already know. The clinical trainer should develop thoughtful questions which will deepen the participants' understanding of the concepts or skills presented in the training session. These questions can be answered individually or by small groups (pairs or trios). Examples of such questions, called process questions, include:

After observing a counseling role play:

- "What were the behaviors you observed that made this clinician effective with this client?"
- "How comfortable are you practicing these behaviors?"
- "How will you know you are being successful when you behave in these ways?"

After participating in a coaching session with a participant:

- "Take the next few minutes to fill out the *Coaching for Clinical Skills: Self-Assessment Guide*. Select three specific areas in which you excelled and three specific areas in which you would like to improve. After you have made your list, choose a partner with whom to discuss your self-assessment."

After the discussion in pairs:

- "Be prepared to report to the total group one area in which you excelled and one area you want to improve."

Using questions in this way illustrates several concepts. By using the *Coaching for Clinical Skills: Self-Assessment Guide* (**Sample 7-2**), the participants take responsibility for observing and monitoring their own behavior and learning. There is a balance in asking them about what they did well and what they want to improve. In choosing a partner with whom to discuss these items, each participant realizes that there are others who also need to improve. Finally, reporting to the group as a whole has the potential for reinforcing behavior changes.

When developing questions, the clinical trainer returns to the objective stated for the session. The questions are then crafted to support the participants in integrating their new learning with their previous experience.

Summaries

The purpose of the summary following a learning activity is to highlight the main points of the activity and bring the session to a close. Several useful suggestions for summaries are included in **Chapter 3**.

When clinical trainers first use interactive training techniques, the activity itself often becomes central to the discussion. It is important to remember that the activity is merely a vehicle to demonstrate a concept or skill the participants need to learn. The critical point is whether the participants'

new ways of thinking or doing something will continue after the training. While application of the clinical training is not within the control of the clinical trainer, insights into the application clearly are among the trainer's responsibilities. The summary provides the opportunity for the clinical trainer to reinforce the participants' learning and to further challenge the group toward excellence.

Trainer's Notes

Many clinical trainers find that preparing "trainer's notes" assists them in identifying key points to guide each presentation. If the trainer clearly understands the flow and timing of the learning activities, a smooth, organized training session will result. Outlining each step of a learning

activity requires the most planning. Trainer's notes can be developed using one or more of the following approaches:

- Highlight key terms and add notes and questions on the pages of the reference manual; **Sample 9-3** is a sample of a reference manual page on which the trainer has written notes and questions.
- Put notes on overhead transparencies.
- Put notes on pages of a flipchart.
- Put notes on slides.

The following example, which was developed based on suggestions in the course outline, can be used as a guide in preparing for a learning activity.

Example of Outline and Timing of a Learning Activity in an IUD Clinical Skills Course

Objective: Load the Copper T 380A IUD in the sterile package.

10:00	Explain rationale for loading in sterile package.
10:10	Show section of the IUD training video.
10:20	Demonstrate loading the IUD (depending on size of the group, it may be necessary to do this twice so that all participants can observe the demonstration).
10:30	Practice (Round I): Ask participants to turn to the *Learning Guide for IUD Clinical Skills* and review Step 2 of Pre-Insertion Tasks. Divide group into pairs and distribute IUDs in sterile packages. **Instructions**: One person loads the IUD in the sterile package while the second person reads each step aloud from the learning guide. Participants then switch roles. The clinical trainer circulates around the room, coaching where needed. After the first practice round is completed, the clinical trainer asks, "What helped you accomplish this task?" and "What was difficult for you in accomplishing this task?"
10:50	Practice (Round II): Same instructions and activity as above (participants build on what they learned in Round I).
11:00	Summarize session, including review of rationale and summary of cost analysis studies for this particular country.

Dealing with Problem Participants

Experienced clinical trainers can share many stories about difficult moments with individual participants or training groups. A necessary training skill for every trainer to learn is how to handle problem participants without decreasing the motivation and the learning rate of all the other participants. The majority of participants in a clinical skill course who cause interruptions do so unintentionally, without realizing the effect they are creating. To further complicate matters, the disruptive behaviors of one or more participants can quickly spread to the others.

Although there is no one way to handle a problem participant, there are a few basic strategies that can be helpful:

- Never embarrass or "put down" the problem participant in front of the others.
- Handle the situation early, before it becomes a serious matter.
- Always use tact and diplomacy.
- Manage personal feelings and remain in control; never show annoyance or lose your temper.

Below is a list of common situations with problem participants that can occur during a clinical skill course, and the corresponding potential solutions that trainers can use to deal with them.

Problem:	**A participant wants to talk all of the time.**
Possible Solutions:	Show that you are actively listening by summarizing the participant's point of view, and then move the discussion forward.
	Ask other participants for their input.
	Ask the problem participant to hold off until a break.
Problem:	**A participant wants to talk about a topic unrelated to the current discussion.**
Possible Solutions:	Ask the problem participant to wait until later in the course (if appropriate).
	Ask the participant to meet with you during the next break or at the end of the day to discuss the topic.
Problem:	**A participant continually talks with another participant.**
Possible Solutions:	Use nonverbal methods to regain their attention (e.g., make eye contact, move closer).
	Ask the problem participant a question (make sure to say the participant's name first).
	Ask these participants if they have a question.
	Ask them (privately, if possible) to refrain from talking.
Problem:	**A participant strongly expresses disagreement with what the trainer says.**
Possible Solutions:	Summarize the participant's point of view and ask other participants for their opinions.
	Agree to disagree.
	Agree in part and then state how you differ and why.
Problem:	**A participant has a distracting habit (e.g., pencil tapping, pen clicking, paper shuffling, etc.).**

Possible Solutions:	Use nonverbal methods to get the participant's attention (e.g., eye contact).
	Ignore the behavior if it is not detracting from the session.
	Privately ask the participant to stop.
Problem:	**A participant is working on something else during the training session.**
Possible Solutions:	Use nonverbal methods to get the participant's attention (eye contact, moving closer).
	If a group activity is underway, ask that everyone participate.
	Each time the participant returns to the other work, direct a question to this participant.
	Privately ask the person to participate actively in the course.
Problem:	**By arriving late or coming and going at will during the course, a participant does not respect the training schedule.**
Possible Solutions:	Adhere to the course schedule; do not let everyone suffer because of one participant's lateness.
	Remind participants of the course schedule.
	Ask the participant a question about content that was presented when this person was not in class, not to embarrass but to show that important information is being presented.
	Privately request promptness (as a courtesy to the rest of the group, not just to the trainer).
Problem:	**A participant does not participate at all during the discussion.**

Possible Solutions:	Use nonverbal means (e.g., eye contact, smiling) to draw the person into the discussion.
	Direct discussion questions to the participant.
	Interact with the participant during breaks.
	Ask the participant to be the leader in a small group activity.
Problem:	**A participant does not complete assignments.**
Possible Solutions:	Reemphasize the purpose of the assignments.
	Be sure always to discuss assignments after they are completed to show the value of the assignment.

The ways in which problem situations are handled will give further credibility to the clinical trainer's leadership. Dealing with problems promptly and effectively will allow more time to concentrate on giving presentations and leading discussions.

GIVING KNOWLEDGE AND SKILL ASSESSMENTS

Situation 4: You are attending a clinical skills course and understand that in order to be "qualified" you will need to demonstrate mastery of specific knowledge and skills before the end of the course. According to the course schedule, the midcourse questionnaire is to be administered tomorrow afternoon. The trainer has just announced, however, that since there are only eight participants, the course will finish one day early. Consequently, the midcourse questionnaire will be administered this afternoon after the last session has been presented. You point out to the trainer that this will not allow the participants sufficient time to study the material from the last session. She agrees and says that during the last presentation she will stress "key points" you should remember for the test. As a future clinical trainer, what advice would you give to the trainer regarding how the midcourse questionnaire is being administered?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Knowledge Assessment

Clinical trainers need to prepare themselves before giving a knowledge assessment (pre- or midcourse questionnaire):

- Refrain from any special coaching on the subject matter in an attempt to reduce anxiety and frustration.
- Make certain that the testing area is ready.

- Make sure that there are adequate supplies for the test.
- Review the test procedures.
- Rehearse by reading the instructions.
- Try to anticipate any questions that might be asked before the test begins.
- Make arrangements so that participants being tested will not be interrupted.

Two factors that are important in giving the test are **providing instructions** and **setting time limits**.

Giving Instructions to Participants. To perform to the best of their abilities, participants must know the purpose of the assessment and the basic rules under which they will be tested. This means that they must be aware of the **time allowed**, the manner in which they are to **select and record answers** and the **scoring system** used. The clinical trainer should review the instructions with the participants before they begin answering the questions. Instructions for selecting answers must be written carefully. Stating directions with too much detail is better than stating them with too little.

Setting Time Limits. Many individuals fail to do well when faced with the pressures of a timed assessment. Time limits (if used) should be based on a trial run of the questionnaire. As a general rule, clinical trainers should allow participants about twice the time it takes a clinical trainer to read through and complete the assessment.

The **precourse questionnaire** is not intended to be a test but rather an assessment of what the participants, individually and as a group, know about the course content. Participants are often unaware of this, however, and may become anxious and uncomfortable at the thought of being "tested" in front of their colleagues on the first day of a course. The clinical trainer should be sensitive to this concern and administer the questionnaire in a neutral and nonthreatening way, as the following guide illustrates:

- Participants draw numbers to assure anonymity (e.g., from 1 to 12 if there are 12 participants in the course).
- Participants complete the precourse questionnaire.
- The clinical trainer gives the answers to each question and the participants check their own answers.

- The clinical trainer circulates the Individual and Group Assessment Matrix (see **Sample 6-2**) for participants to complete according to their number.

- The clinical trainer posts the completed matrix.

- The clinical trainer and participants discuss the results of the questionnaire as charted on the matrix and jointly decide how to allocate course time.

Skill Assessments

Even the best designed checklists will not be successful in measuring performance if they are not used correctly. To facilitate the use of checklists, the clinical trainer should be certain that the:

- Classroom or clinic is equipped with all equipment, materials and other supplies necessary to complete the assessment

- Setting for evaluation of clinical skills is as similar as possible to the environment in which the participant normally works

- Instructions are carefully reviewed with the participants and any questions are answered before the assessment begins

QUALIFICATION

Situation 5: You have been asked to conduct a course for IUD service providers. In this course you will be presenting information to the participants, and they will be practicing clinical skills with anatomic models and with clients. During the course overview, one of the participants asks you, "How will we be tested to make sure we are qualified to provide IUD services when we complete this course?" How do you answer this question?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Much controversy surrounds the issue of determining **qualification in clinical training**. Most people believe that clinicians are qualified to perform a procedure or activity when they have demonstrated a defined level of skill competency and can maintain that level after training. In practice, **objective measurement of clinical competence during training may be very difficult**, and it is still more difficult to measure competence **after** training.

Because of this difficulty, in the past many organizations equated being qualified with completion of a specified number of supervised procedures. Clearly, while some participants can achieve competency after only a few practice cases, others may require several more, and a very few may never achieve an acceptable level of competency. Therefore, determining whether or not a participant is qualified should be based on **observed** and **measured** performance using competency-based (knowledge, attitude and skill) assessments rather than on completion of a set number of practice cases.

When anatomic models are used for initial skill acquisition (e.g., training in IUD or Norplant implants insertion), nearly all participants will be judged to be **competent** after only a few cases with clients. **Proficiency**, however, invariably requires additional practice. Therefore, when training participants who will become new service providers (i.e., they have had no prior experience), participants may need to perform the procedure with at least 5 to 10 clients in order to feel **confident** about their clinical skills. Thus, the judgment of a skilled clinical trainer is the most important factor in determining whether participants are qualified. **Sample 9-4** is a sample Statement of Qualification from an IUD Clinical Skills course.

Qualification is a statement by the training institution(s) that the participant has met the requirements of the course in knowledge, skills and practice areas. Qualification does **not** imply certification, which is granted only by an authorized organization or agency.

Qualification may be based on the participant's achievement in three areas:

- **Knowledge.** A recommended score of at least 85% on the Midcourse Questionnaire.

- **Skills.** Satisfactory performance of clinical activities and skills as evaluated by the clinical trainer using a competency-based skills checklist. In determining whether the participant is competent, the clinical trainer will observe and rate the participant's performance for each step of the skill or activity. The participant must be rated "satisfactory" in each skill or activity to be evaluated as competent.

- **Practice.** Demonstrated ability to provide client services in the clinical setting. During the course, it is the clinical trainer's responsibility to observe each participant's overall performance in providing client services. As part of this observation, the clinical

trainer can assess the impact on clients of the participant's **attitude**—a critical component of quality service delivery. Only by doing this can the clinical trainer evaluate the way the participant uses what has been learned.

Training clinical trainers to use competency-based performance instruments, such as those described above, in a reliable manner provides an opportunity to base competency on demonstrated performance and application of knowledge in the clinical setting, rather than on "lecture time" or number of practice cases performed.

As discussed in **Chapter 1**, responsibility for the participant becoming qualified is shared by the participant and the trainer.

Sample 9-5 shows a sample of a form which records information about the participant (e.g., name, date and topic of course attended, scores on questionnaires). Both the trainer and the participating agency should keep copies of this form for future reference. It is recommended that, if possible, course graduates be observed and evaluated in their institution, within 3 to 6 months of completing a course, by a **course trainer** using the counseling and clinical skills checklist that was used in the course. At the very least, the graduate should be observed by a **skilled provider** soon after completing training.

This postcourse evaluation or followup activity is important for several reasons. First, it provides the learner direct feedback not only on performance, but also provides the clinical trainer and learner the opportunity to discuss any startup problems or constraints to service delivery (e.g., lack of instruments, supplies or support staff). Second, and equally important, it provides the training center, via the clinical trainer, key information on the adequacy of the training and its appropriateness to local conditions. Third, it affords the trainer an opportunity to meet with the clinical supervisor to discuss the post-training performance of the service provider. Without this type of feedback, clinical training easily can become routine, stagnant and irrelevant to service delivery needs.

EVALUATING THE COURSE

Situation 6: You and a cotrainer are conducting a clinical skills course. The day before the course ends your cotrainer asks you about allowing the participants an opportunity to provide written feedback about the course. You remember that this is mentioned in the course schedule, but you both have been so busy that you forgot to prepare for this. What kinds of questions should you include in the end-of-course written evaluation?

Write your response on a piece of paper and then compare your response with the one found at the end of this chapter.

Evaluation is an integral part of the clinical training process. Evaluation can determine whether the training has met its goals (i.e., whether participants' knowledge, attitudes and skills improved) and identify aspects of the course that should be strengthened. As discussed above, evaluation of participant achievement is accomplished through competency-based knowledge and skill assessments (see **Chapter 6**).

Evaluation of **participant reaction** to the course is also important in the clinical training process. It should occur both during and at the end of the course. To determine how participants like the course and how they perceive its value, participants can be asked to use one of the following methods:

- Daily reactions (oral or written)
- End-of-course written evaluations
- End-of-course informal reactions of participants

Daily Reactions

Clinical trainers should continually monitor the training. Daily monitoring encourages participants to think and talk about what they learned during the day and to make suggestions to the entire group about how to improve the course. Such monitoring can be conducted as a participant-led exercise at the end of each training day. A useful technique is to have participants:

- Write on a piece of paper the two or three most important ideas or concepts that they learned during the day, as well as suggestions for course improvement.
- Share with the group one or two items from their lists.

End-of-Course Written Evaluations

Course evaluations allow trainers to identify the:

- Extent to which the course met participants' expectations
- Aspects of the course that participants found the most or least helpful
- Relevance of the course content to the participants' work
- Appropriateness of the training methodology
- Extent to which administrative aspects of the course were satisfactory (e.g., the training environment, accommodations, travel arrangements)

When developing end-of-course written evaluations, the clinical trainer should be guided by the following considerations:

- Including some close-ended questions allows trainers to easily tabulate data and identify response patterns.
- Including some open-ended questions allows participants an opportunity to share their feelings.
- Using a rating scale for evaluation items is recommended. If the majority of participants rate an item very high or very low, it is usually worth the trainer's attention.
- Ensuring participants' anonymity encourages truthful responses.

The clinical trainer should schedule sufficient time during the course for participants to complete the evaluations. Evaluations should **not** be distributed late on the last day of training when participants are tired and may be preparing to depart. **Sample 9-6** can be used by participants to evaluate the trainer. **Sample 9-7** is an example of an IUD course evaluation to be completed by participants at the end of training.

End-of-Course Informal Reactions

Informal discussions can accompany the formal written evaluation so that the clinical trainer can better understand the reaction evaluation data. For example, participants can be asked, individually or in small groups, to discuss the following questions:

- "What were your expectations for the course? To what degree were they met?"
- "Based on the stated course objectives, did you learn what you expected to learn?"

Answers to these questions can be summarized by a group reporter during

this session and shared with the clinical trainer(s) either orally or in writing.

Alternatively, the clinical trainer can select several aspects of the course (e.g., course content, training methods, administrative arrangements), and ask participants to write their reactions anonymously. Participant comments can be posted under their respective category headings on flipchart sheets or on a writing board. The clinical trainer or a participant can then lead a general discussion with the participants about the comments.

Daily Clinical Trainer Meetings

If there is more than one clinical trainer conducting the course, it is important that the trainers meet briefly each day to discuss the participants' evaluation of the day's training activities, as well as each clinical trainer's personal assessment of the training. This exercise may identify elements of the clinical training that need to be changed.

HELP AND FOLLOWUP AFTER TRAINING

Application of Clinical Learning

Clinical training often fails to produce long-term results when attention is not given to transferring training to the workplace. Application of newly acquired skills to the job is not the responsibility only of the participants. The clinical trainer and the training/service delivery organization should make every effort to ensure that each participant has the opportunity, resources and motivation to apply the learning on the job. This is especially true for the complex surgical skills learned in clinical training.

New skills and activities such as counseling, IUD insertion and infection prevention practices need to be practiced soon after training or they will be lost and never applied.

Clinical trainers can ensure that training is effective, stays with each participant and gets applied on the job by:

- Using training activities that promote transfer of the new skill or activity to the workplace
- Contracting (developing action plans)
- Providing for followup sessions

Effective Transfer of Skills

Before training starts, there should be a clear idea of how the participants will use newly acquired clinical skills. The clinical trainer should know that

all parties—supervisors, participants and other trainers—understand and agree to what the participants will be expected to do after returning to the job. Any resources, including time, staff support, equipment and supplies needed to carry out the new skills should be planned for before the participants enter training, not after resuming their work.

In addition to the pretraining planning needed to ensure transfer of new skills back to the workplace, there are a number of other training activities which will increase the probability that participants will use their new skills. For example, **any training activity that is seen by the participant as realistic and work-related will increase the likelihood that what has been learned will be applied**. Finally, skill practice with clients, problem-solving discussions and role plays give the participant confidence to apply new skills effectively and avoid the embarrassment of failure while on the job.

The following training materials and activities also can increase transfer of training to the job:

- Problem-solving **reference manuals and handouts** which participants can use to refresh their memories once they return to their jobs
- **Learning guides** which summarize the key steps of a skill or activity
- **Analysis of work-related barriers** to applying skills
- **Role plays** focusing on ways to deal with difficult situations on the job
- **Action planning** to map out how and when new skills will be applied
- **Training people in** "**teams**" from the same work unit (e.g., training the counselor and the service provider together)

Contracting

Another way that clinical trainers can increase learning transfer is "**contracting**" with course graduates about implementation of their action plans. In this context, a "contract" means a **nonlegal pledge to carry out a plan**. It should pledge action by the person (e.g., to perform a specific number of procedures or to report on difficult cases) as well as action by the clinical trainer (e.g., to consult on problem cases or provide help in overcoming barriers).

To be effective, these contracts should include the following elements:

- **Early commitment.** Secure commitment for goals (action plan) early in the training or before the training begins, if possible.

- **Realistic goals setting.** Make sure that goals are specific, measurable, achievable and realistic.

- **Public discussion.** Provide opportunities for discussion of action plans with fellow participants. Feedback helps create realistic planning, discussion can create a support network of colleagues who can help carry out the plans, and public commitment increases the likelihood that the plans will be implemented.

- **Monitoring procedures.** When possible, build in opportunities for clinical trainers or local expert service providers to visit a participant's work site to monitor progress in carrying out the action plan. When personal visits are not possible, write or telephone to check on implementation of the plan.

Followup Sessions

Most clinical trainers know that training followup is essential, but few actually do it. The excuses are many and include:

- "I have no time."
- "I have no budget."
- "I have other courses to conduct."

Perhaps clinical trainers would take followup more seriously if they realized that **relapse** (participants who go back to their pretraining ways of doing things) **rates can be as high as 90% without followup**.

Followup can be almost any contact between the clinical trainer and participants that helps the participants apply what they learned more effectively. **The more intensive and frequent the followup, the more likely it will support transfer of learning.** For effective followup, the clinical trainer can:

- Send relevant articles to participants after training
- Exchange correspondence about successes and problems
- Encourage participants to "network" and support each other
- Send equipment or supplies to support the work
- Make personal visits to consult on problems or meet with supervisors
- Organize refresher training to renew and extend skills
- Arrange followup meetings with training groups to share experiences and discuss mutual problems

SUMMARY

Conducting an effective clinical training course requires extensive planning and work before, during and after the course. In addition to following the planning guidelines presented in **Chapter 2**, the clinical trainer must prepare for and conduct each training session. This involves reviewing each of the components of the learning package and then preparing and conducting each classroom presentation and clinical practice activity in the course schedule. If there are "problem participants" in the course, the trainer will need to know strategies for dealing with these participants and keeping the training session moving forward. In order to determine if the participants have mastered the knowledge and skills outlined by the course objectives, the trainer will administer knowledge and skill assessments. The trainer will also use a variety of evaluation techniques to determine the effectiveness of the course. Following the course, the trainer should visit each service provider and the immediate supervisor to ensure that the knowledge, attitudes and skills acquired during training have been transferred to the clinic site, resulting in improved performance and the provision of high quality services to clients.

SITUATION RESPONSES

Situation 1 Suggest to the trainer that she highlight key words or phrases in the reference manual. This will allow her to glance at the page, focus on a few key words and bring her attention back to the participants. She could also put the key points on overhead transparencies or flipchart pages. These techniques will allow her to move around the room to interact with the participants more effectively.

Situation 2 As a participant in a course, you are probably interested in the course goals and objectives; the identity and background of the other participants; the course schedule and specific learning activities which will occur; and the learning materials you will be using. You might also appreciate the opportunity to share your expectations.

Situation 3 Planning some small group role plays during a counseling session is a good idea. Where the trainer went wrong was deciding to do this suddenly without sufficient planning. The trainer should have given the participants a short break and then taken a few minutes to write the activity instructions on the flipchart. This would have given the trainer time to think through the activity, and the participants could have referred to the flipchart when working in their groups.

Situation 4 The clinical trainer should have made the decision about changing the course schedule earlier, in order to let the participants know that the midcourse questionnaire would be administered sooner than originally planned. In addition, the trainer should refrain from special coaching to help participants do better on the test.

Situation 5 In order to be "qualified," each participant must score at least 85% on the midcourse questionnaire and demonstrate mastery (according to the steps in the competency-based checklist) of clinical skills both with anatomic models and clients.

Situation 6 Include some close-ended questions based on the course goals and objectives (e.g., "I feel confident in Copper T 380A IUD insertion and removal") with an appropriate rating scale. Include also some open-ended questions (e.g., "What did you like the most about this course?") to allow participants to share their feelings about the course.

MODEL IUD COURSE SCHEDULE (Standard Course: 10 days, 20 sessions)

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
0830–1200	**0830–1200**	**0830–1200**	**0830–1200**	**0830–1200**
Opening • Welcome • Participant expectations **Overview of course** • Goals and objectives • Approach to training • Review of course materials **Precourse Questionnaire** Identify individual and group learning needs **Exercise**: "How People Learn"	**Review** day's scheduled activities **Demonstration**: Standard Copper T 380A insertion and removal methods using: • slide set • videotape • pelvic model **Exercise**: How to use the learning guides for IUD clinical skills **Tour of Clinic Facilities**	**Review** day's scheduled activities **Review key steps** in: • Counseling a client • IUD insertion/removal **Classroom Practice**: Divide into two groups to practice: • Counseling a client • IUD insertion/removal using pelvic models Participants assess each other's performance using learning guides	**Review** day's scheduled activities **Classroom Practice**: Divide into two groups to practice: • Counseling a client • IUD insertion/removal using pelvic models Participants assess each other's performance using learning guides or practice checklist	**Review** day's scheduled activities **Classroom Practice**: Divide into two groups to practice: • Counseling a client • IUD insertion/removal using pelvic models Participants assess each other's performance using practice checklist Trainer assesses participants for skill competency on models
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
1330–1630	**1330–1630**	**1330–1630**	**1330–1630**	**1330–1630**
Precourse Assessment Assess each participant's skills: • Counseling (role play) • Pelvic exam (pelvic models) **Lecture/Discussion**: Key features of Copper T 380A IUD **Demonstration and Practice**: Loading the Copper T 380A IUD in the sterile package **Review of the day's activities**	**Review** of counseling methods: • Framework for family planning (FP) counseling • Essential components • Characteristics of a good counselor **Role Play**: Divide into teams to practice counseling: • FP acceptor • IUD acceptor Participants assess each other's performance with learning guides **Review of the day's activities**	**Discussion**: • How IUDs work • Indications, precautions and other conditions • Client screening and assessment **Exercise/Discussion**: Reducing risk of HBV and HIV/AIDS transmission in FP clients **Exercise**: "Who Has AIDS?" **Review of the day's activities**	**Discussion/Videotape**: Role of infection prevention practices in IUD services • Definitions • Handwashing and use of gloves • Processing instruments • Waste disposal **Demonstration**: In simulated clinical area, demonstrate infection prevention practices for each step of IUD insertion/removal **Review of the day's activities**	**Discussion**: Managing GTIs in family planning clients • Simplified approach to diagnosing GTIs • Client screening and assessment • GTIs and IUD use **Midcourse Questionnaire** **Review of the day's activities**

MODEL IUD COURSE SCHEDULE (Standard Course: 10 days, 20 sessions)

Reading Assignment: Chapters 1, 2, 7 and Appendix A	**Reading Assignment**: Chapters 3, 4 and Appendix B	**Reading Assignment**: Chapter 6	**Reading Assignment**: Chapter 5	**Reading Assignment**: Chapters 1, 8 and 9

MODEL IUD COURSE SCHEDULE (Standard Course: 10 days, 20 sessions)

DAY 6	DAY 7	DAY 8	DAY 9	DAY 10
0830–1200 **Review** day's scheduled activities **Clinic Practice**: Provide IUD services in the clinic: • Counseling clients • GTI screening • Client assessment • IUD insertion • IUD removal (if available) • Followup care • Management of problems Participants assess each other's performance using practice checklist	**0830–1200** **Review** day's scheduled activities **Clinic Practice**: Provide IUD services in the clinic: • Counseling clients • GTI screening • Client assessment • IUD insertion • IUD removal (if available) • Followup care • Management of problems Participants assess each other's performance using practice checklist	**0830–1200** **Review** day's scheduled activities **Clinic Practice**: Provide IUD services in the clinic: • Counseling clients • GTI screening • Client assessment • IUD insertion • IUD removal (if available) • Followup care • Management of problems Competency-based evaluation by clinical trainer using checklist (qualification)	**0830–1200** **Review** day's scheduled activities **Clinic Practice**: Provide IUD services in the clinic: • Counseling clients • GTI screening • Client assessment • IUD insertion • IUD removal (if available) • Followup care • Management of problems Competency-based evaluation by clinical trainer using checklist (qualification)	**0830–1200** **Review** day's scheduled activities **Clinic Practice**: Provide IUD services in the clinic: • Counseling clients • GTI screening • Client assessment • IUD insertion • IUD removal (if available) • Followup care • Management of problems Competency-based evaluation by clinical trainer using checklist (qualification)
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
1330–1630 **Clinical Conference** **Discussion**: Management of side effects and other problems **Demonstration/Exercise**: Management of lost strings and lost IUDs (hand-held and pelvic models) **Role Play**: Managing side effects Clinical trainer reviews results of Midcourse Questionnaire with each participant (½ class) **Review of the day's activities**	**1330–1630** **Clinical Conference** **Discussion/Role Play**: Postinsertion and followup care **Discussion**: Indications for removal **Role Play**: Counseling a client for followup care after IUD removal. Clinical trainer reviews results of Midcourse Questionnaire with each participant (½ class) **Review of the day's activities**	**1330–1630** **Clinical Conference** **Discussion**: Assessing and improving quality of IUD services **Discussion**: Organizing and managing an IUD service **Review of the day's activities**	**1330–1630** **Clinical Conference** **Discussion**: Medical barriers and policy issues **Discussion**: Problems and constraints to IUD service delivery in participant's own clinical setting **Review of the day's activities**	**1360–1630** **Clinical Conference** **Discussion**: Course accomplishments relative to objectives, training methods and materials **Course Evaluation** by participants **Closing**
Reading Assignment: Chapters 8 and 9	**Reading Assignment**: Chapters 10 and 11			

MODEL IUD COURSE OUTLINE (Standard Course: 10 days, 20 sessions)			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS**
Session One: Day 1, AM			
(45 minutes)	**Opening** **Objective**: Identify participant expectations	**Warmup Exercise** **Discussion**	
(30 minutes)	**Objective**: Describe course goals and objectives, approach to clinical training, materials and schedule	**Discussion**	**IUD Reference Manual** (1 per participant) **IUD Course Handbook** (1 per participant)
(30 minutes)	**Objective**: Assess participants' precourse knowledge	Complete Precourse Questionnaire	**Handbook**: Precourse Questionnaire
(15 minutes)	**Break**		
(30 minutes)	**Objective**: Identify individual and group learning needs	**Exercise**: Group grades questionnaires and completes Individual and Group Assessment Matrix	**Handbook**: Individual and Group Assessment Matrix
(60 minutes)	**Objective**: Describe how people learn and identify adult learning characteristics	**Exercise/Discussion**: • Activity 1: Loading TCu 380A IUD in sterile package or Building a Box • Activity 2: Numbers Game • Activity 3: Nine Dots Puzzle	**Handbook**: "How People Learn"
TOTAL: 210 minutes		**Equipment for course** • 35 mm slide projector and screen • Overhead projector • Videotape player (VCR) • Blackboard/chalk (or flipchart/marker pens)	• ZOE® pelvic models • Hand-held uterine models • IUD insertion/removal kits • Copper T IUDs in sterile packages

MODEL IUD COURSE OUTLINE (Standard Course: 10 days, 20 sessions)			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS**
Session Two: Day 1, PM			
75 minutes	**Objective**: Assess each participant's skill in: • Counseling • Performing a pelvic exam	Clinical trainers assess participant skills individually • Counseling skills (role play by participants and with volunteers) • Clinical skills using pelvic model Clinical trainers complete Precourse Assessment Checklist for each participant and review results individually	ZOE pelvic model **Trainer's Notebook**: Precourse Assessment Checklist for IUD Counseling and Clinical Skills
15 minutes	**Break**		
30 minutes	**Objective**: Describe key features of the Copper T 380A IUD	**Lecture/Discussion**	**Reference Manual**: Chapter 1
45 minutes	**Objective**: Learn to load the Copper T 380A IUD in the sterile package	**Demonstration**: Loading the Copper T 380A IUD in the sterile package (demonstrated by the trainer) **Exercise**: Participants practice loading the IUD in the sterile package	Copper T 380A IUDs in sterile packages (1 per participant) **Reference Manual**: Appendix K
15 minutes	**Objective**: Review of the day's activities	**Discussion**	
TOTAL: 180 minutes			
Reading Assignment: Reference Manual; Chapters 1, 2, 7 and Appendix A. **Course Handbook**: Overview and Introduction			

SAMPLE 9-3

PAGE WITH TRAINER'S NOTES FROM A REFERENCE MANUAL

TWO

COUNSELING

BACKGROUND

There are various reasons why individuals and couples decide to start, continue or stop practicing family planning. Some people may wish to delay the birth of their first child, while others may want to space the birth of their children, and some may want to ensure that only a desired number of children are born. There also are people who may wish to use family planning services not so much for protection from unplanned or unwanted pregnancy, but for other reasons, including achieving pregnancy or for the protection of their reproductive and sexual health.

CLIENT RIGHTS

Any member of the community who is of reproductive age should be considered a potential client of family planning services. All individuals in the community have a right to information about family planning for themselves and their families, regardless of their ethnic origin, socio-economic status, religion, marital status or political belief. All persons also have a right to decide freely whether or not to practice family planning.

Family planning programs should assist people in the practice of informed free choice by providing unbiased information, education and counseling, as well as an adequate range of contraceptive methods. Clients should be able to obtain the method they have decided to use provided the method is available.

A client's concepts of acceptability and appropriateness change with circumstances. Therefore, the client has the right to decide when to start, stop or switch methods.

Clients also have the right to discuss their concerns in an environment in which they feel confident. The client should be aware that her conversation with the counselor or service provider will not be listened to by other people.

When a client is undergoing a physical examination it should be carried out in an environment in which her right to bodily privacy is respected. The client's right to privacy also includes the following aspects related to quality of services:

- When receiving counseling or undergoing a physical examination, the client should be informed about the role of each individual inside the room (e.g., service providers, individuals undergoing training, supervisors, instructors, researchers, etc.).

- A client should know in advance the type of physical examination which is going to be undertaken. The client also has a right to refuse any particular type of examination if she doesn't feel comfortable with it.

A client should feel comfortable when receiving family planning services. To a certain extent this is related to the adequacy of service delivery facilities (e.g., proper ventilation, lighting, seating and toilet facilities). Moreover, the time the client spends at the premises to receive requested services should be reasonable.

SAMPLE 9-4

STATEMENT OF QUALIFICATION

_____

(Name of Organization)

hereby attests that

_____

is qualified as an

IUD Service Provider

This is based on the successful completion of the IUD Clinical Skills Course

conducted in/at

_____

(Course Site)

_____

(Month, Days, Year)

_____	_____	_____
Representative of the Organization	*Trainer*	*Trainer*

____ This participant has satisfactorily completed a midcourse questionnaire covering the information presented in this course.

____ In addition, this participant has demonstrated mastery of the following IUD clinical skills, with both anatomic models and clients:

____ Pelvic examination

____ Preinsertion counseling

____ Insertion of Copper T 380A IUD

____ Postinsertion counseling

____ Preremoval counseling

____ Removal of Copper T 380A IUD

____ General counseling

SAMPLE 9-5

FORM FOR RECORDING PARTICIPANT DATA

Participant's Name _____ Participant's Institution_____

Participant's Address_____ Participant's Profession_____

Course Title _____ Location of Course_____

Dates of Course_____ Trainer's Name_____

Precourse Questionnaire score (if available)_____

Midcourse Questionnaire score_____ (Attach questionnaire to this form)

Number of times participant took midcourse questionnaire_____

Counseling and Clinical Skills Evaluation _____Satisfactory _____Unsatisfactory
(Attach completed checklist to this form)

Provision of services (Practice) _____Satisfactory _____Unsatisfactory

Was participant "qualified" as a result of completing this course? _____Yes _____No

Skills or clinical services provision in which participant was assessed as competent:

_____ IUD insertion/removal

_____ Norplant implants insertion/removal

_____ Minilaparotomy using local anesthesia

_____ Laparoscopy using local anesthesia

_____ No-scalpel vasectomy (NSV)

_____ Postabortion care (PAC)

_____ Infection prevention (IP)

_____ Genital tract infections (GTIs)

_____ Clinical training skills

_____ Other

If participant was **not** qualified as competent, briefly state the reason(s):

_____

_____

_____

_____

SAMPLE 9-6

EVALUATION OF CLINICAL TRAINER

(To be completed by **Participants**)

Name of clinical trainer: _____

Instructions: Please indicate on a 1 to 5 scale your opinion of the performance of the clinical trainer.

5-Strongly Agree **4-Agree** **3-No opinion** **2-Disagree** **1-Strongly Disagree**

THE CLINICAL TRAINER:	**RATING**	**COMMENTS/ SUGGESTIONS**
1. Made me feel welcome when I entered the course		
2. Showed sensitivity to my natural feelings of fear and anxiety when learning new skills		
3. Showed or admitted her/his limitations on the subject		
4. Encouraged interaction with all participants		
5. Made it easy for me to ask questions and express my concerns		
6. Assessed my skills before training		
7. Clearly stated objectives of the new skills or activities to be learned		
8. Established clear standards for the performance expected of me		
9. Gave reasons why each step of the skill or activity is important		
10. Demonstrated each new skill or activity following the learning guide		
11. Demonstrated the skill or activity through role play or by using models before demonstrating on client(s)		
12. Provided me with enough opportunities to practice and achieve competence in the new skills or activities		
13. Gave me specific and immediate feedback so I knew how well I was performing		
14. Met with me to discuss my performance following each practice session		

Other Comments:

SAMPLE 9-7

IUD COURSE EVALUATION

(To be completed by **Participants**)

Instructions: Please indicate your opinion of the course components using the following rating scale:

5-Strongly Agree **4-Agree** **3-No Opinion** **2-Disagree** **1-Strongly Disagree**

COURSE COMPONENT	RATING
1. The Precourse Questionnaire helped me to study more effectively.	
2. The role play sessions on counseling skills were helpful.	
3. There was sufficient time scheduled for practicing counseling through role play with clients and volunteers.	
4. The slide set and videotape helped me get a better understanding of how to insert and remove IUDs prior to practicing with the pelvic model.	
5. The practice sessions with the pelvic model made it easier for me to perform a Copper T 380A IUD insertion and removal when working with actual clients.	
6. There was sufficient time scheduled for practicing IUD insertion and removal with clients.	
7. The interactive training approach used in this course made it easier for me to learn how to provide IUD services.	
8. Ten days were adequate for learning how to provide IUD services.	
9. I feel confident in Copper T 380A IUD insertion and removal.	
10. I feel confident in using the infection prevention practices recommended for IUDs.	
11. I feel confident in screening clients for GTIs.	

ADDITIONAL COMMENTS

1. What topics (if any) should be **added** (and why) to improve the course?

2. What topics (if any) should be **deleted** (and why) to improve the course?

APPENDIX A

ADAPTATION OF THE COMPONENTS OF A LEARNING PACKAGE

LEARNING PACKAGE COMPONENTS	ADAPTATION OF COMPONENTS
Course Handbook/Notebook	
Course Syllabus	Should be revised to reflect changes to the course description, goals, participant selection criteria, evaluation criteria and participant learning objectives.
Course Outline	Should be revised to reflect new content, revised time allocations, new teaching/learning methods, new materials and audiovisuals.
Course Schedule	Should be revised to show the new schedule. Copies should be distributed to participants, posted on a flipchart or attached to the wall.
Learning Guides and Checklists	In most situations, these instruments are not revised for a single course or series of courses. Typically, these instruments are developed for a specific method and may be adapted for use in a given country.
Precourse and Midcourse Questionnaires	When there are significant changes to the participant learning objectives, then it is assumed that there are changes to the information being taught. When this is the case, the precourse and midcourse questionnaires should also be revised to reflect what is being taught.
Course Evaluation Form	The course evaluation form will need to be revised to reflect the information presented and skills developed during the course.
Other Components of the Learning Package	
Reference Manual	The reference manual(s) used in a course would not be revised for a single course or series of courses. Specific chapters may not be taught or supplemental information may be added by distributing handouts, but the manuals would not be changed.
Supporting Audiovisuals	In most cases, revising a course will require the addition of audiovisuals (e.g., new overhead transparencies, flipcharts).
Anatomic Models	Adapting a course for most reasons would not require additional anatomic models unless a new clinical skill were being added to the course or if more participants were expected.

LEARNING PACKAGE COMPONENTS	ADAPTATION OF COMPONENTS
Statement of Qualification (**Note**: This statement is not a part of the learning package, but is directly affected by changes to the course content and objectives.)	The "statement of qualification" presented to participants at the conclusion of a clinical skill or clinical training skills course (and practicum, if required) indicates that the individual is qualified to provide a specific FP method or to train others to provide this method. **Under no circumstances should individuals receive this statement if they have not met the criteria outlined in the original course syllabus.**

APPENDIX B

ENERGY-HEIGHTENING ACTIVITIES

BOOM!

OBJECTIVE: Fun, Concentration

MATERIALS: Chairs

APPROXIMATE TIME REQUIRED: 10 minutes

STEPS:

1. All participants sit in a circle. They are instructed to count out loud around the circle. Each person whose number is a **multiple of 3** (3-6-9-12, etc.) or a number that **ends with 3** (13-23-33, etc.) must say **BOOM!** instead of the number. The next person continues the normal sequence of numbers.

   Example: the first person starts with **1**, the next one says **2**, the person who should say **3** says **BOOM!** instead, and the next person says **4**.

2. Anyone who fails to say **BOOM!** or who makes a mistake with the number that follows **BOOM!** is disqualified.

3. The numbers must be said rapidly (5 seconds maximum); if a participant takes too long to say her/his number, s/he is disqualified.

4. The last two participants are the winners.

Note: The game can be made more complex by using multiples of bigger numbers, or by combining multiples of three with multiples of five.

Source: Unknown.

USE OF SAYINGS UNIQUE TO EACH COUNTRY

OBJECTIVE: Fun, Concentration

MATERIALS: Flipchart, markers, envelopes, chairs

APPROXIMATE TIME REQUIRED: 10 minutes

STEPS:

1. At the beginning of the week, as a warmup exercise, form groups of three or four participants. Ask each group to record some of the sayings frequently used in their country. After 5 to 7 minutes, ask the groups to report their list of sayings. As each group reports their list, the trainer should check that the entire group understands each saying.

   Keep this list of sayings for another warmup later in the week. Write each saying on a piece of paper and place in an envelope.

2. Later in the week (the third or fourth day), divide the participants into two groups, one group at each end of the room.

3. One representative from each group comes to the center of the room to receive an envelope containing a saying. The representatives read the sayings (silently) and return to their groups.

4. Without speaking, the representatives draw a picture to represent the saying they have received. The drawings cannot contain any words or parts of words.

5. The members of each group guess the saying that their representative has drawn. The first team to guess the correct saying receives one point.

6. After one group has guessed the saying, all groups send a new representative to the center to receive another envelope with a saying and the activity proceeds as described above.

7. The activity continues for 10 minutes or until all the sayings have been drawn and identified. The group with the higher number of points wins.

Source: Unknown.

HOT PEPPER

OBJECTIVE: To boost the energy level in the group (good to use after lunch)

MATERIALS: Small ball

APPROXIMATE TIME REQUIRED: 10 to 15 minutes, depending on the size of the group

STEPS:

1. Participants sit in a circle away from the conference table and close their eyes.
2. Trainer gives a small ball to one participant who is instructed to pass the ball quickly to the next person saying "**Hot**!" Participants continue to pass the ball around the group.
3. As the ball is passed from participant to participant, the trainer turns her/his back, closes eyes and calls out "**Pepper**!"
4. The person who is holding the ball when "**Pepper**!" is called is removed from the circle.
5. The ball continues to be passed until only one person is left.

Adapted from: Pfeiffer & Company 1983.

NEW CONCEPTS

OBJECTIVE: To focus participants on the content of the training session

MATERIALS: Flipchart

APPROXIMATE TIME REQUIRED: 5 minutes

STEPS:

1. Form three or four small groups.
2. Write the word **INTERACTIVE** on the flipchart.
3. The groups have 5 minutes to create as many 3-letter words as possible from the word **INTERACTIVE**.
4. Call time after 5 minutes. The group with the most words wins.

Note: Depending on the topic, other words can be used in this way, such as “demonstration,” “counseling,” etc.

Source: Unknown.

WHERE YOU STAND DEPENDS ON WHERE YOU SIT

OBJECTIVE: To encourage participants to broaden their horizons, and look upon their environments as opportunities, not as limitations

MATERIALS: One transparency or handouts (one for each participant) of the top half of the figure

APPROXIMATE TIME REQUIRED: 5 to 10 minutes

STEPS:

1. Present the top half of the figure on the next page to participants, preferably by projection onto a screen so that everyone can see it at the same time.
2. Ask how many people think that Circle A is larger and how many think Circle B is larger.
3. Demonstrate, by revealing the bottom half of the figure, that both circles are really the same size.

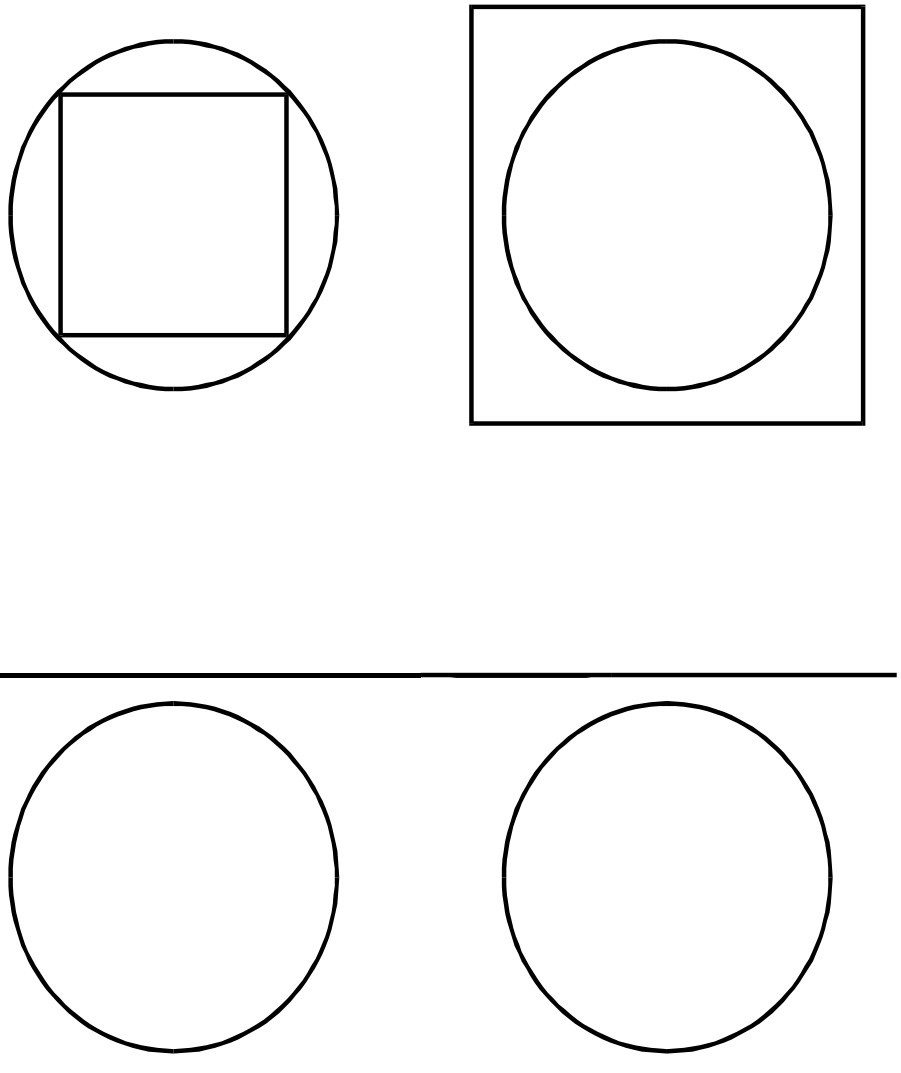
DISCUSSION QUESTIONS:

1. Why does one circle appear larger than the other?
2. In what ways do we let our minds work in similar fashion as we view our worlds? What impact does this tendency (i.e, to focus on constraints, problems and barriers) have on our own productivity?
3. How can we prevent or diminish our tendency to limit our own thinking pattern like this?
4. Does the saying "Where you stand depends on where you sit" hold equally true regarding our thought processes and perceptions (e.g., "what we perceive is what we will react to")?

Source: Ryder Systems, Inc. 1987.

WHICH CIRCLE APPEARS LARGER?

A **B**



THE SPIDER WEB

OBJECTIVE: Introductions (for participants who do not know each other well)

MATERIALS: A ball of yarn, cord or thin rope

APPROXIMATE TIME REQUIRED: 10 minutes (depending on size of group and length of introduction)

STEPS:

1. The participants stand up and form a circle.

2. A ball of yarn is given to one participant who tells the group something about her/himself, such as name, where s/he is from, her/his type of work, why s/he is attending the course, etc. (The information to include will depend on the size of the group and the time allotted for the activity.)

3. The participant with the ball of yarn holds onto the end of the yarn and throws the ball to a colleague in the circle, who in turn must introduce her/himself in the same way. Participants continue introducing themselves by tossing the ball around the circle until all participants form part of this **spider web**.

4. As soon as everyone has introduced her/himself, the person holding the ball (Z) returns it to the person who threw it to her/him (Y), as s/he (Z) repeats the information about that person (Y).

   Person Y then returns the ball to the person who threw it to her/him (X) repeating her/his information. This continues around the circle, with the ball following its previous path in reverse order until it reaches the participant who first introduced her/himself.

Note: Warn the participants beforehand of the importance of paying attention to each introduction, since they will not know who will be throwing the ball at them.

Source: Unknown.

HIDDEN SQUARES

OBJECTIVE: To encourage participants to dig deeper into problems, and visualize them from a different perspective; to see not only the whole, but also various combinations of parts.

MATERIALS: A flipchart, transparency or handout with the figure shown on the next page

APPROXIMATE TIME REQUIRED: 10 minutes

STEPS:

1. Provide participants with a drawing of a large square, divided as shown on the next page. Then direct them to quickly count the total number of squares seen, and report that number verbally.

2. The correct answer is 30, developed as follows: 1 whole square, 16 individual squares, 9 squares of 4 units each, and 4 squares of 9 units each.

DISCUSSION QUESTIONS:

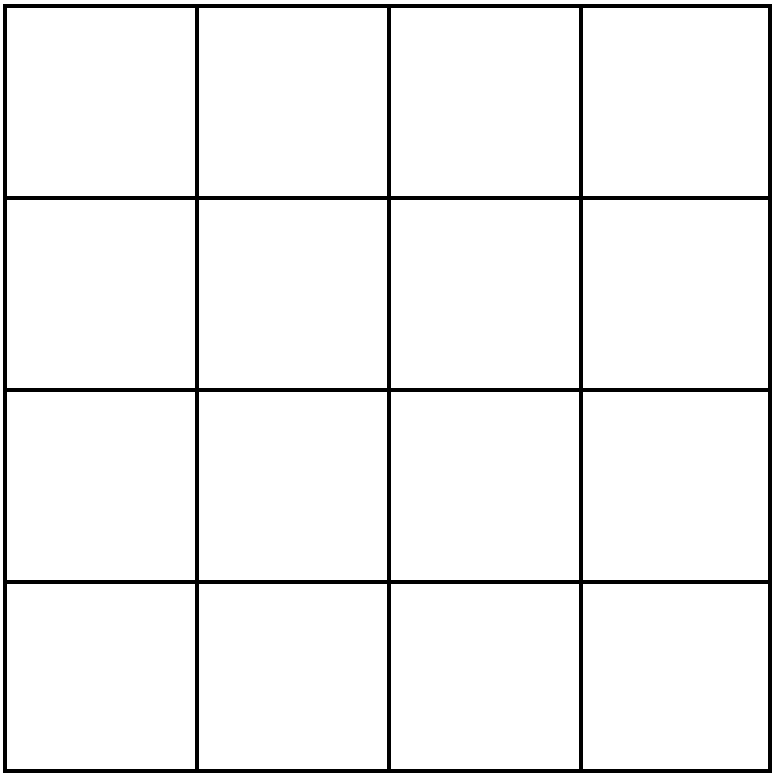
1. What factors prevent us from easily obtaining the correct answer? (We stop at the first answer, we work too fast.)

2. How is this task like other problems we often face? (Many parts make up the whole.)

3. What can we learn from this illustration that can be applied to other problems?

Source: Newstrom and Scannell 1980.

HIDDEN SQUARES



WARMUP EXERCISE: THE POST OFFICE

OBJECTIVE: Fun, liveliness

MATERIALS: Chairs

APPROXIMATE TIME REQUIRED: 10 to 15 minutes (depending on size of group)

STEPS:

1. The participants sit in a circle, each having her/his own chair. The facilitator takes one chair away and the participant who is left standing stands in the center of the circle and begins the activity.

2. The participant in the center of the circle says something like:

   "I bring a letter for all of my colleagues who have brown hair."

3. All of the participants who have the characteristic stated (e.g., brown hair) **and** the person in the center of the circle change places.

4. Whoever ends up without a chair to sit on stands in the center of the circle and again states that s/he is bringing a letter, but for people with a different characteristic, such as:

   "I bring a letter for all of my colleagues who are wearing black shoes."

   "I bring a letter for all of my colleagues who have never inserted a Copper T 380A IUD."

5. The activity can continue as long as the group is interested and enthusiastic (but no longer than 15 minutes).

Source: Unknown.

GLOSSARY

Active Listening Communication technique that stimulates open and frank exploration of ideas and feelings and enables trainers to establish trust and rapport with participants. In active listening, the trainer accepts what is being said without making any value judgments, clarifies the ideas or feelings being expressed and reflects these back to the participants.

Advanced Trainer Trainer who can transfer both clinical skills and clinical training skills to proficient service providers. The advanced trainer should also be knowledgeable and experienced in adapting and conducting various types of reproductive health courses. Generally, an advanced trainer first has been a proficient service provider, then a clinical trainer and has completed an advanced training skills course and practicum (i.e., cotrained) with a master trainer.

Audiovisuals Materials used to supplement learning activities. Audiovisuals highlight key steps or information, reinforcing the learning process. They include writing boards, flipcharts, transparencies, slides and videotapes.

Behavior Modeling Learning a skill or activity by watching someone else (model) perform it proficiently. (See also **Skill Acquisition, Skill Competency** and **Skill Proficiency**.)

Brainstorming Learning strategy that stimulates thought and creativity and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions which focus on a specific topic or problem. Brainstorming requires that participants have some background related to the topic.

Case Study Interactive learning method using real scenarios that focus on a specific issue, topic or problem. It is used primarily to strengthen knowledge. Typically, participants read, study and react to the case study in writing or orally during a group discussion.

Certification Process for documenting that a participant can competently provide a service(s) (e.g., IUD or Norplant implants insertion and removal). Certification is bestowed by an authorized organization (Ministry of Education or Health), educational institution (medical or nursing school) or agency. **Generally, training organizations do not certify participants.** (See also **Competency**.)

Checklist Competency-based (skill) assessment instrument that is used to evaluate a participant's performance of clinical skills or other observable behaviors (e.g., counseling or presentation skills). Checklists focus on the **key steps**

or tasks of a procedure or activity. They are used by trainers to evaluate performance of a procedure or activity objectively.

Clinical Skills Course Training course for clinicians (e.g., physicians, nurses, midwives) during which they acquire the skills needed to **competently provide** a clinical service (e.g., IUD or Norplant implants insertion/removal). Clinical skills courses usually focus on one contraceptive method (e.g., IUDs or minilaparotomy), although some courses may include a combination of contraceptive methods. (Also known as Service Providers' Course.)

Clinical Skills Trainer/Clinical Trainer Trainer who can transfer clinical skills to service providers. A clinical skills trainer must be proficient (expert) in the clinical service for which she or he will be providing training, as well as competent in clinical training skills. To become a clinical skills trainer, the trainer must complete a clinical training practicum (i.e., cotrain) with an advanced or master trainer.

Clinical Training Skills (CTS) Course Training course during which proficient (expert) service providers (e.g., physicians, nurses, midwives) acquire the training skills needed to competently train other health professionals in how to provide a clinical service (e.g., minilaparotomy under local anesthesia).

Clinician Anyone who provides clinical services in the health system (e.g., physician, medical assistant, nurse, nurse-midwife, midwife or paramedic). (See also/compare to **Service Provider**.)

Clinical Instructor Clinician who has responsibility for training students in the clinic. The clinical instructor may be either a service provider or a member of the preservice faculty. (Also known as a **Clinical Preceptor**.)

Clinical Preceptor Clinician who has responsibility for training students in the clinic. The clinical preceptor may be either a service provider or a member of the preservice faculty. (Also know as a **Clinical Instructor**.)

Coaching Learning approach that involves the use of positive feedback, active listening, questioning and problem-solving skills to ensure a positive learning climate. The trainer/coach demonstrates desired performance standards, encourages openness to learning and continually assesses participant performance. An effective coach focuses on practical issues, encourages working together, works to reduce stress and is a facilitator of learning.

Competency Ability to perform a skill to a specific standard and apply knowledge in the provision of services. (See also **Skill Competency**.)

Competency-Based Training (CBT) Competency-based training is learning by **doing**. It emphasizes how the participant **performs** (i.e., a combination of knowledge, attitudes and, most important, skills) rather than what information the participant has **learned**. In CBT, participants' progress is continually measured against pre-established performance criteria (standards).

Competency-Based Skill Assessment Instrument Instrument used to objectively measure clinical (psychomotor) skills or other observable behaviors (e.g., counseling).

Course Handbook (Participant) Document that outlines the framework for a training course. It contains a course syllabus and schedule as well as all supplemental printed materials (precourse knowledge questionnaire, individual and group learning matrix, learning guides and course evaluation) needed during the course.

Course Notebook (Trainer) Document that outlines the framework for conducting a training course and provides additional information and instructions for the trainer. A Trainer's Notebook includes all the material given to the participant as well as the course outline; precourse skills assessment; precourse knowledge questionnaire answer key; midcourse knowledge questionnaire, answer sheet and answer key; and the participant evaluation form.

Course Outline Detailed plan of topics to be presented in a course and **how** the training will be delivered. The course outline is a planning document.

Course Schedule Brief day-by-day description of the major activities to be conducted in a training course. Information for the course schedule is taken from the course outline.

Course Syllabus Summary of the major components of a course. The syllabus should be given to participants in advance of training. It is important that a syllabus accurately describe the course content, goals and objectives (also know as a Course Description).

Demonstration (Clinical) Interactive learning technique in which the trainer explains and shows the steps, and sequence if necessary, required to perform a skill or activity. A variety of methods can be used to demonstrate a procedure, including slides, videotapes, anatomic models and role play.

Discussion (Group) Interactive learning technique in which most of the ideas, thoughts, questions and answers are developed by the participants. The trainer serves as the facilitator and guides participants as the discussion develops.

Feedback Communication technique in which the trainer (or coach) provides

information to participants about their progress in mastering a skill or activity or achieving the learning objectives of the course. Feedback is most effective when it is timely (provided immediately), positive and descriptive.

Group Dynamics Forces present among individuals who come together to form a group.

Group Norms Patterns of behavior identified, agreed upon and enforced by the group in order to ensure the accomplishment of its objectives.

Group Process Interaction of members of a group.

Humanistic Training Clinical training technique that uses anatomic models and other learning aids such as slide sets and videotapes to enable participants to reach the performance levels of **skill acquisition** and beginning **skill competency** before working in the clinical setting with clients. Humanistic training facilitates learning, shortens training time and minimizes risks to clients.

Illustrated Lecture Training method in which the content is derived largely from the knowledge-based learning area and presented orally and visually by the clinical trainer. Its effectiveness as a training method is markedly enhanced through the use of questioning techniques and well-designed audiovisual aids such as slides, transparencies and videotapes.

Inservice Training Training for health professionals who have completed their preservice education and have graduated from a school that gives degrees or certificates. This training is job-related and provides them with additional knowledge and skills to carry out new job functions or to improve performance of existing job functions.

Learning Life-long process of acquiring new knowledge, attitudes and skills. It may occur formally during a learning event or informally during personal reading or study.

Learning Event An activity conducted for the purpose of transferring knowledge, attitudes and/or skills to participants. It can take the form of a course, workshop, seminar or topic update.

Learning Guide Competency-based skill development assessment instrument that focuses on clinical skills (e.g., IUD insertion) or other observable behaviors (e.g., counseling). Learning guides contain the individual steps or tasks in sequence (if necessary) required to perform a skill or activity in a standardized way. Learning guides are designed to help the participants learn the correct steps and sequence in which they should be performed (**skill acquisition**) and measure progressive learning in small steps as they gain confidence and skill (**skill competency**).

Learning Package Collection of materials used to conduct a course. Components of a learning package include (but are not limited to) a reference manual; a course handbook for participants; a course notebook for the trainer; audiovisual and other learning aids (e.g., videotapes, slide sets and anatomic models); and competency-based assessment instruments.

Master Trainer Trainer who can transfer advanced and clinical training skills as well as clinical skills to other health professionals. The master trainer should also be knowledgeable and experienced in developing courses, conducting various types of training courses in reproductive health, conducting needs assessments and evaluating training. Generally, a master trainer first has been a proficient service provider, then a clinical trainer and an advanced trainer. Cotraining and conducting instructional design workshops are also part of the master trainer's role.

Mastery Learning Approach to learning that is based on the premise that **all** participants can master (learn) the required knowledge, attitudes and skills, provided sufficient time is allowed and appropriate training methods are used. The goal of mastery learning is that 100 percent of the participants will "master" (learn) the knowledge, attitudes and skills on which the training is based.

Midcourse Questionnaire Competency-based knowledge assessment that allows each participant and the clinical trainer to determine the participants' progress in mastering the course material.

Participant Individual receiving training; also known as student, trainee or learner. The term participant is preferred, particularly for postgraduate health professionals receiving training.

Participatory Learning Method of training which actively involves participants in the learning process.

Precourse Questionnaire Competency-based knowledge assessment that is administered at the beginning of a course to determine what the participants, individually and as a group, know about the course topic. The assessment allows the clinical trainer to identify particular topics which may need emphasis or, in many cases, require less classroom time during the course. Providing the results to participants enables them to focus on their individual learning needs.

Preservice Education Learning that takes place in undergraduate and graduate educational institutions (e.g., medical, nursing and midwifery schools).

Procedure (Medical) Encompasses all of the individual steps/tasks required to perform a medical intervention (e.g., the IUD insertion procedure includes client

assessment and infection prevention practices as well as the clinical aspects of inserting the IUD).

Proficiency See **Skill Proficiency**.

Psychomotor Domain Area of learning that often involves performing skills which require the manipulation of instruments and equipment (e.g., inserting an IUD).

Qualification A statement by the training institution that a participant has met the requirements of a course in knowledge, skills and practice. Qualification does not imply certification, which is done only by an authorized organization or agency.

Questionnaire Set of **validated** and **reliable** questions used to assess the participant's precourse knowledge or to measure mastery of the course material (e.g., **Pre- and Midcourse Questionnaires**).

Reference Manual Text containing essential, need-to-know information pertaining to a specific skill or activity (e.g., IUD insertion, infection prevention, clinical training skills). The reference manual contains all of the information needed to conduct a training course in a logical manner. It serves as the text for participants and the "reference source" for the trainer.

Role Play Interactive learning method in which participants act out roles in a realistic situation related to learning objectives. It is used primarily to affect behavior. A major advantage of this approach is that participants can experience a real life situation without taking real life risks.

Service Provider Anyone who provides a service at any level in the health system (e.g., physician, nurse, midwife, community-based distribution [CBD] worker). (For comparison, see **Clinician**.)

Skill Group of tasks that use motor functions and typically require the manipulation of instruments and equipment (e.g., IUD or Norplant implants insertion, minilaparotomy). **Activity** is often used synonymously, but may or may not require motor functions. **Steps** and **Tasks** are subcomponents of skills and activities.

Skill Acquisition Represents the **initial phase** in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and, if necessary, the sequence in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

Skill Competency Represents an **intermediate phase** in learning a new skill or activity. The participant can perform the required steps, in the proper sequence if

necessary, but may not progress from step to step efficiently.

Skill Proficiency Represents the **final phase** in learning a new skill or activity. The participant efficiently and precisely performs the steps, in the proper sequence if necessary. Proficiency is attained through repeated practice of the skill or activity. It usually is not obtainable in a basic (introductory) clinical or training skills course.

Standardization Process of analyzing the essential steps in a skill or activity to determine the most efficient and safe way to perform it and train others. A standardized procedure provides the basis for developing learning guides, checklists and clinical learning packages. Individuals who have been "standardized" in a skill or activity will perform it using the standard, agreed-upon steps/tasks.

Steps Specific actions needed to accomplish a skill or activity. (**Tasks** often used synonymously.)

Tasks Skills or activities broken down into specific actions, assignments or duties. (**Steps** often used synonymously.)

Teaching Transferring or conveying knowledge. Teaching usually refers to instruction provided through classroom activities (often associated with preservice education programs).

Trainer Person who has knowledge and skills in a specified subject area and the ability and training to transfer them to others. Trainers are proficient (expert) in the skills and activities in which they provide training. In addition, they have received specialized training and practice in training skills.

Training Process which deals primarily with transferring or obtaining the knowledge, attitudes and skills needed to carry out a specific activity (e.g., IUD insertion). Training should be based on the assumption that there will be an immediate application of the physical or mental skill(s) being learned (as differentiated from education, which is most often directed toward future goals).

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• Learning Packages • Service Provision Guidelines • • Workshop Proceedings • Strategy Papers •

LEARNING PACKAGES

Each of the JHPIEGO learning packages described below contains all the materials needed to deliver a given course. The central element of each learning package is the reference manual, which contains the need-to-know information for the course and is modular in design. It is complemented by a handbook for participants, a notebook for trainers and selected audiovisual materials and learning aids. The handbook for participants describes a competency-based training course and includes the course objectives, model course schedule, learning guides and practice checklists, all linked to the reference manual. The notebook for trainers contains the precourse and midcourse questionnaires and answer keys and competency-based qualification checklists, in addition to all participant material. Handbooks and notebooks usually are provided in a ratio of one trainer's notebook for every five participant's handbooks.

IUD

IUD Guidelines for Family Planning Service Programs provides clinicians (physicians, nurses and midwives) with essential information on how to provide IUD services (specifically the Copper T 380A IUD) safely. The material is arranged sequentially, according to the usual way in which clients are cared for—beginning with counseling and ending with management of side effects and other health problems. (2nd edition, 1993) Available in English, Portuguese, Russian and Spanish. (1st edition, 1992, available in French.)

IUD Training Video—*Insertion and Removal of the Copper T 380A IUD*. This training video presents a systematic approach to the safe and gentle insertion of the Copper T 380A IUD featuring a "no touch" insertion technique. The video includes sections on IUD insertion and removal and managing problems with IUDs. (1998) Available in English, French, Portuguese, Russian and Spanish.

Norplant® Implants

Norplant® Implants Guidelines for Family Planning Service Programs provides clinicians (physicians, nurses and midwives) with essential information on how to safely insert and remove Norplant implants. The material is arranged sequentially, according to the usual way in which clients are cared for—beginning with counseling and ending with management of side effects and other health problems. (2nd edition, 1995) Available in English and Russian. (1st edition, 1993, plus a 2nd edition supplement of Chapters 3, 8 and 9, available in French.)

Norplant Implants Training Video—*Removal of Norplant® Capsules Using the "U" Technique*. This video demonstrates the "U" technique for removal of Norplant capsules, which has been found to be faster and easier to perform and easier to learn than the standard technique for removal. It also is useful in removing hard-to-remove capsules. (1996) Available in English and French.

Postabortion Care

Postabortion Care: A Reference Manual for Improving the Quality of Care, produced by the Postabortion Care Consortium, provides clinicians with essential information on the safe and effective management of incomplete abortion and the life-threatening complications of unsafe abortion. The manual outlines the full range of activities needed to provide appropriate, high quality postabortion care, including family planning and referral to healthcare services needed after emergency treatment. The material in this manual is arranged sequentially according to the usual way in which patients are cared for—starting with the initial assessment of their condition and ending with the provision of followup care, including family planning and other reproductive health services. (1995) Available in English, French, Portuguese and Spanish.

Postabortion Care Video Photoset—*Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments*. This photoset, a series of still photos captured on a 30-minute video, has been developed as a clinical training tool. It is designed to assist healthcare professionals in learning how to treat women with complications following incomplete abortion. It is divided into two main sections: treatment of incomplete abortion using MVA and how to process MVA instruments. (1996) Available in English, French and Spanish.

Postabortion Care Video—*Postabortion Care: A Global Health Issue*. Produced by the Postabortion Care Consortium, the video provides an overview of the problem of unsafe abortion and the need for postabortion care. It also describes the three elements of postabortion care: emergency treatment of incomplete abortion and potentially life-threatening complications; postabortion family planning counseling and services; and links between postabortion emergency services and the reproductive healthcare system. It is designed to introduce the concept of postabortion care to policymakers as well as to clinicians. (1994) Available in English, French, Portuguese, Russian and Spanish.

Infection Prevention (IP)

Infection Prevention for Family Planning Service Programs is designed to enable clinic administrators, managers and healthcare professionals to develop uniform IP standards for use in any type or size of family planning service program. The goal of IP is twofold: preventing infection in the client and providing protection to both clients and healthcare workers. The three sections of the manual cover basic IP principles, practical and easy-to-do IP practices for each surgical contraceptive method, and "how to" instructions for using the recommended procedures. (1992) Available in English, French, Portuguese, Russian and Spanish.

Infection Prevention Training Video—*Infection Prevention for Family Planning Service Programs*. Produced in collaboration with AVSC International, this video emphasizes the dual role of IP in minimizing postoperative infections in clients and preventing serious disease transmission (hepatitis B and HIV/AIDS) to both clients and healthcare staff. It also documents practical, easy-to-do IP practices that minimize costs and the need for expensive technology and/or fragile equipment. The trainer's notes, included with the video, are designed to help trainers use the material effectively. (1994) Available in English, French, Portuguese, Russian and Spanish.

Training Skills

Clinical Training Skills for Reproductive Health Professionals is designed for the expert service provider who wishes to become a clinical trainer. It focuses on the essential areas of clinical skills training including planning for a training course, creating a positive learning climate, using audiovisual aids, delivering interactive presentations, using competency-based assessment instruments, developing clinical skills, managing clinical practice and conducting the clinical training course. (2nd ed, 1998) Available in English; available in French and Spanish, Summer 1999. (1st ed, 1995, available in Portuguese.)

Instructional Design Skills for Reproductive Health Professionals is written for those trainers and preservice faculty members who will function as instructional designers to design, deliver and evaluate reproductive health courses, workshops, seminars and other learning events. It is designed to be used for both inservice and preservice training. (1997) Available in English and French.

SERVICE PROVISION GUIDELINES

PocketGuide for Family Planning Service Providers is designed to provide clinicians with easily accessible, clinically-oriented information about contraceptive methods and family planning clients. It is intended to be used by clinicians when they need immediate answers to questions about a client's condition or a contraceptive method. The easy-to-find information is organized into sections on providing services (e.g., client assessment, infection prevention), specific contraceptive methods (e.g., natural family planning, oral contraceptives, voluntary sterilization) and contraception for clients with special needs (e.g., adolescents, clients with chronic medical problems). (2nd edition, 1996) Available in English, French and Russian.

Service Delivery Guidelines for Family Planning Service Programs give service providers at all levels basic information on all contraceptive methods currently available. They are based on the most up-to-date knowledge and consensus opinions and complement the more detailed information available in the *PocketGuide for Family Planning Service Providers*. The *Guidelines* are designed to be adapted to meet a specific country's needs. (1996) Available in English and French.

WORKSHOP PROCEEDINGS

Issues in Cervical Cancer: Seeking Alternatives to Cytology summarizes a workshop held to review the status of cervical cancer screening worldwide and discuss alternative methods of detecting cervical cancer. (1994) Available in English.

Learning Without Walls: A Pre-Congress Seminar contains presentations and discussion on the information revolution from a seminar held in Bali, Indonesia, in conjunction with the XVth Asian Oceanic Congress of Obstetrics and Gynecology. (1995) Available in English.

Issues in Management of STDs in Family Planning Settings summarizes a workshop held to explore options for introducing management of STDs into family planning programs. (1996) Available in English.

Issues in Training for Essential Maternal Health Care summarizes a workshop cosponsored by JHPIEGO and MotherCare II which focused on the development of strategies for maternal healthcare training; improvement of training materials; and identification of practical training approaches. (1997) Available in English.

Alternatives for Cervical Cancer Screening and Treatment in Low-Resource Settings summarizes a workshop which focused on screening and treatment options for cervical cancer and on approaches for low-resource settings where the disease has already been identified as a public health priority. (1998) Available in English.

STRATEGY PAPERS

JHPIEGO strategy papers are designed to summarize JHPIEGO's experience in reproductive health capacity building, with a focus on education and training. The papers are intended for use by program staff of JHPIEGO, USAID and its cooperating agencies and other organizations providing or receiving technical assistance in the area of reproductive health training.

The Competency-Based Approach to Training (1995) Available in English and French.

Why Do We Lecture? (1996) Available in English and French.

On-the-Job Training for Family Planning Service Providers (1996) Available in English.

Infection Prevention: A History of Change (1996) Available in English.

Delivering Effective Lectures (1996) Available in English and French.

Accelerating the Reduction of Maternal Mortality in Developing Countries (1997) Available in English.

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ASSESSMENT OF CLINICAL TRAINING SKILLS REFERENCE MANUAL

Please indicate on a 1–5 scale your opinion of the manual.

5-Excellent 4-Very Good 3-Satisfactory 2-Needs Improvement* 1-Unsatisfactory*

CONTENTS	Easy to read	Need-to-know information	Samples	Usefulness in problem solving
Overall Evaluation of Manual: Clinical Training Skills for Reproductive Health Professionals, 2nd ed				
CHAPTER				
1 An Approach to Clinical Training				
2 Planning for a Training Course				
3 Creating a Positive Learning Climate				
4 Using Audiovisual Aids				
5 Delivering Interactive Presentations				
6 Using Competency-Based Assessment Instruments				
7 Developing Clinical Skills				
8 Managing Clinical Practice				
9 Conducting a Clinical Training Course				
APPENDIX				
A Adaptation of the Components of a Learning Package				
B Energy-Heightening Activities				
GLOSSARY				

* Please comment on the back if you rated any chapter or appendix less than satisfactory.

COMMENTS:

1. What topics (if any) should be included in **more detail** to improve the manual?

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ADDITIONAL COMMENTS:

PLEASE RETURN ASSESSMENT TO:

JHPIEGO Corporation
Learning and Performance Support Office
Brown's Wharf
1615 Thames Street, Suite 200
Baltimore, MD 21231-3492, USA